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## ORIGINAL DEPARTMENT.

### COMMUNICATIONS.

#### TREATMENT OF CHRONIC DISEASES, WITH SPECIAL REFERENCE TO INDIGESTION.

BY W. M. HEPBURN, M. D.,  
Of Freehold, N. J.

(Concluded from page 515.)

In acute cases strong drugs may be used in large doses or in small doses frequently repeated, with most marked effect, but with few exceptions—such as opium in cancer, potass. iodid. in syphilis—chronic diseases not only do not call for such treatment but are often aided in their course by the reckless use of medicines in the hands of thoughtless, incompetent, or criminally guilty M. D.s. Take for instance morphine in “sick headache.” Well, would you forbid a hypodermic to a patient suffering excruciating pain? The question presents itself in another form, Can I conscientiously give morphine to this patient, who has been, and will continue to suffer until the cause is discovered, and, if possible, removed? Can I give morphine, knowing that in all probability the habit will be formed which, in its evil effects, far exceeds the disease? Of course I can relieve this attack, the sufferer and the family will be grateful, but soon I will be called again to do the same. The disease is not necessarily fatal, and by proper diet, protection of the body, exercise, occupation, etc., I have known cases wonderfully benefited.

Yet the cure will be slow; but knowing that, by persevering efforts, I can and ultimately will relieve the patient, also knowing the telling effect of sudden relief, and the unwillingness of people

to control and regulate their actions, am I guilty if I bend to the wishes of the patient and family, and use anodynes when the pain calls for them? I think we all believe I would be doing wrong.

In giving morphia and kindred drugs, we give not with the expectation of curing the disease, but relieving the pain. If I give pepsin I simply add to the amount of gastric juice. Iron but increases one of the normal constituents of the blood. Cod-liveroil, being the most digestible fat, but adds to our combustible material, and so adds to the warmth and vigor of the body. But when I give morphine, I am giving a drug which ultimately will destroy the healthiest digestion, the brightest mind, and wreck the most vigorous constitution, which destroys all pleasurable living to the patient, and to the family.

Do I use opiates? Most assuredly; in acute cases in any dose indicated. But do I use them in chronic diseases? Yea; for example, take the following case: Mrs. N., married, two children, had all her adult life suffered to some extent during her periods, and was troubled with what is commonly called “sick headache.” Treated by various western doctors, she at last sought advice of Dr. Thomas, of New York. He came to the conclusion that the only possible relief was to be obtained by removal of the ovaries; that she was then too much broken down for the operation; but that after a trip to Europe had set up her health he would, on her return, operate. Dr. Jack saw the patient in June, 1883. She was then in the second day of the period, and under one of her headaches. These began in one side of the head, and the pain gradually increased until the patient lost consciousness, the limbs becoming rigid, the

hands clenched, the eyes half open and turned up, and shivering fits came on every few minutes. Dr. Jack introduced his hypodermic needle, and injected  $\frac{1}{2}$  grain of morphia. Left the needle in, and in a few seconds relief was obtained; but as it was not complete at the end of five minutes, he gave the same quantity and withdrew the needle. Pain subsided, and did not return during that period, but she suffered from severe sickness. In a few days ordered iron and quinine, with shower-baths, good food, and early hours. When next period was expected he gave belladonna and potass. brom., and when the period came on, kept the patient in bed, applied small blisters over each ovary, and ordered a morphine pessary at night. Afterward the tonic treatment was resumed, and soon with entire relief of the patient. Had the morphia failed except in larger and continuously repeated doses, to accomplish the end for which it was used, the surgical operation would have been far preferable. I have not the slightest doubt but that the reason why the morphine was continuously decreased was the tonic treatment, food, rest, etc., thus assisting nature to supply nourishment, good food, etc., and so, at last, to throw off these wretched attacks.

My experience in my own practice, and the accumulated experience of others, teach me that it is only by careful attention to all the necessities of the whole system that we really benefit our patients.

It is simply remarkable how the attention of the profession is more and more turned to the effects of food, rest, etc., and the consequent reduction in the amount of medicines used. For illustration, I quote from two celebrities, one on the treatment of brain exhaustion, and the other on epilepsy, both of which are certainly tedious and intractable enough in their usual course, to discourage the most enthusiastic. The doctor, giving his treatment for brain exhaustion, says:

"The subject is secluded in a dark room from ten to fifteen hours at a time, according to the amount of sleep which it is desired shall be had during the twenty-four hours. The amount of sleep is progressively increased by habit, moderate medication, and hydrotherapy, and no attempt is made to produce a sudden state of stupor by the reckless use of sedatives. When the patient awakes, as is usually the case two or three times during the hours set apart for rest, nourishment is given, but always in a fluid and easily-digested form.

"Where difficulty is experienced in again falling asleep, resort is had in the beginning to limited medication.

"The few hours of wakefulness are devoted exclusively to some forms of amusement—reading, writing—even the mildest forms of mental concentration being absolutely prohibited. This in brief is the method from which I have already seen most happy results, and from the employment of which I hope and believe much good, in the future, will be derived.

"Rest, however, for those cells, the function of which is the evolution of mind, can only be obtained by a prolonged period of absolute unconsciousness; and this, as a matter of course, will often tax the patience and resources of the physician to the utmost."

As regards epilepsy, I quote the following: "I wish to speak a little further in regard to the influence of diet in cases of epilepsy, for it is one of the fundamental features of the scientific treatment of this disease.

"In some cases in which the irritation of the stomach and bowels is manifestly very great, you will find remarkable results from placing the patient on a really rigidly restrictive diet. I have had under my observation for several years a young man who had evidently overworked himself at his trade, and had become an epileptic. Many members of his family had exhibited nervous phenomena of various kinds. This young man was delicate, and after he had worked at his trade (plumbing) for some time, he began to have spinal tenderness, and then vomiting occurred frequently after eating. He was at this time 18 years of age. He grew anæmic, his work became laborious to him, and then he began to have convulsive seizures which were quite severe, and were frequently repeated. This patient also suffered from gastrointestinal catarrh, and he was put to bed, his diet restricted to milk, and minute doses of nitrate of silver and belladonna administered. This treatment was used simply with the view of improving the gastric symptoms, and not with any expectation that it would influence the convulsions: and yet these convulsive seizures which had lasted two years, and which I had treated with a number of remedies without decidedly improving them, gradually grew less frequent, and in a few weeks stopped entirely. The treatment which I have mentioned was then kept up for a number of months, and the result was a perfect cure. \* \* \* I think, therefore, we may say that there is no successful treatment of epilepsy without careful attention to diet, and that in a limited number of cases a cure can be effected by prolonged rest and an absolutely restricted diet."

This same writer speaks of another case of a

boy 10 years of age, an epileptic, of whom he says: "A short time ago I took the boy from school, and ordered him to stay in bed until eleven o'clock in the morning, when he gets up and walks about or plays for a couple of hours, and then goes to bed. His diet is carefully restricted. He is taking cod-liver oil with lacto-phosphate of iron, but no bromides or other remedies to check the attack, yet under this treatment decided improvement is, for the first time, reported."

Speaking of certain symptoms from continued use of bromides, he says: "When these symptoms are produced the bromides are doing more harm than good, even if they control the attack. The use of large doses of bromides under these circumstances may produce secondary trouble more serious than the original."

My first consultation brought with it a lesson which has been of such inestimable good to me, and is so appropriate to the subject, that I feel compelled to relate the case: A child about thirteen months old had always been delicate, and was at the time of which I speak prostrated with chronic diarrhœa, and the attending physician thought malaria. I cannot recall all he was giving the child, but will tell what I remember: Quinine by suppository, Fowler's solution, opium and astringents for the diarrhœa, and brandy as a stimulant, besides large quantities of milk. I say it was my first consultation, and though I believe in many medicines, these struck me as being a little too much; but, as the physician in attendance was double my age, I mildly suggested stopping Fowler's and quinine, and reducing the amount of brandy. The child, however, grew worse, and the mother, and doctor, too, giving up all hope of its recovery, the child was placed on a pillow and taken by its mother to her old home, intending, if it lived to get there—some ninety miles by railroad—to put it under the care of a homeopathist—a graduate of a regular school—in whom she had great confidence. The child had some fifteen passages the day it was taken home, and looked about worn out. To-day that boy is a robust, hearty little fellow. What medicine did the homeopathist use to cure such a desperate case? As I happen to know, I will tell: he used white of an egg, cup of cold water, sugar to sweeten, and teaspoonful of port wine, given ad libitum.

Before closing this article, let me recall a remark I made in regard to the use of drugs in acute cases. I said: "In acute cases strong drugs may be used in large doses, or in small doses frequently repeated with most marked effect."

Now, that is so, but if we continue the medicines too long the "marked effects," may not be what we wish for. I had, one year ago, a case of puerperal fever, and a most discouraging case it was. At last the disease had spent itself, but what a condition it left the woman in! Nauseated, purged, emaciated, weakness itself, death seemed hovering over her ready to grasp his prey. The consulting physician said she could not live twenty-four hours, ordered brandy and milk, quinine, opiates, and astringents for the diarrhœa.

Now, that the woman apparently needed all these could not be disputed, but she could not take them. A few more retchings and purgings, and her last gasp would have been taken.

What then did I give her? What common sense dictated. "I gave her a rest," heat to the body, mustard to the stomach. After some hours teaspoonful doses of a mixture of milk, lime water and brandy were given. The woman, at present, is in most excellent health.

I have, perhaps, become prolix in my effort to enforce my "points," but it does seem to me that we should study earnestly to know the true place medicines should have in our treatment of these discouraging, chronic cases; and the more we study the more we will be convinced of the necessity of carefully and watchfully administering strong drugs; and of the wonderful aids, if rightly used, we have in rest, diet, exercise, pleasant surroundings, protection and support. I hope in my next paper, in studying indigestion in its various forms, pathology, and treatment, to make a practical application of my theories.

FOREIGN BODY IN THE INTERIOR OF THE  
LEFT EYE, OF THREE YEARS' DURATION,  
CAUSING SYMPATHETIC OPHTHAL-  
MIA OF ITS FELLOW—REMOVAL  
OF THE FOREIGN BODY—FULL  
RECOVERY OF THE RIGHT  
EYE—MARKED IMPROVE-  
MENT OF THE LEFT  
EYE.\*

BY M. LANDESBURG, M. D.,  
Of Philadelphia.

I have the honor to exhibit to you, Mr. President to-night one of the most interesting cases I have ever had the good luck to meet with in my practice.

This gentleman, 41 years of age, had the misfortune of being struck by a splinter of metal in

\* Read before the Philadelphia County Medical Society September 17, 1884.

his left eye, July 13, 1881, about six weeks after he had come to this country. Blindness set in within ten minutes after the accident. He applied on the same day at Wills' Eye Hospital, where he was advised to have the eye removed at once. Not quite relishing this prospect, he went to the Jefferson Medical College, where he was admitted for treatment after he had refused the enucleation, which was also at first proposed to him. There he remained for six weeks, during which time the incident inflammation passed off entirely. The globe was preserved, but vision was not restored. He enjoyed good health, until March, 1882, when the first symptoms of sympathetic disorders began to develop in the right eye. Asthenopic troubles made their appearance, followed by sensitiveness to light and photopsies. The acuteness of vision gradually diminished as well for distant as for near objects.

And now he began his wanderings from one oculist to the other; he hardly spared one, if I have to believe his testimony. Nothing was done for the benefit of the right eye, which changed from bad to worse. Enucleation of the left eyeball was pronounced by all authorities as the ultimate ratio by which the condition of "nervous irritation" in its fellow might possibly be checked.

When I saw the patient for the first time, September 5, 1883, I ascertained the following condition:

No irritation whatever in either eye. Vision of the right eye was 10-20; with convex 40, 10-15. Pupil of normal shape, but of somewhat sluggish reaction; accommodation is impaired in consequence of paresis of the accommodative muscle. With naked eye patient reads Jaeger 13 at about fifteen inches distance; with the help of convex 10, Jaeger 3 at eight inches. Field of vision and tension are normal. There exists an eccentric positive scotoma, outside of the point of fixation. The subjective complaints are of photopsies and scintillations. Ophthalmoscopic examination reveals no morbid changes.

Left eye counts fingers at two feet peripherically outwards. The cornea shows a linear horizontal cicatrix on its lower third, running from the outer corneal margin towards the pupillary region. The lower half of the iris is disorganized and presents in its middle a funnel-shaped depression, and close to its temporal border a mound-like elevation. The pupillary margin of this segment of the iris is connected by three blackish filaments, with the dense opaque whitish membrane, which stretches across the whole pupillary plane, filling

up the latter to the greatest extent, even after the pupil had been dilated by a mydriatic.

The presence of the above described "*depression and elevation*" in the lower half of the iris, which were situated just opposite the corneal scar, aroused my suspicion that the foreign body might possibly lay imbedded in this region. An operation for the removal of the foreign body seemed to me to be a matter worth trying at first, by which nothing was risked and everything might be gained. The enucleation of the eyeball I regarded as the last expedient; to which I would resort if I should be baffled in my intentions.

I spoke with the patient to this effect, telling him that I must have full liberty to act according to my best judgment, and to be allowed to enucleate the eyeball if I should fail to extract the foreign body.

He took time for deliberation and reflection until May 19, 1884, when he returned in the following condition. In the meanwhile he had repeated and completed his circuit among the specialists:

"Vision of the right eye 10-30; with convex 60, 10-20; complete paralysis of the muscle of accommodation. With the naked eye he reads Jaeger 16 at eighteen inches distance; with the help of convex 10, Jaeger 5, at ten inches. The shape of the pupil is normal, its reaction sluggish. The visual field is somewhat limited in the upper sector, and its outer upper quadrant is occupied to the greater extent by the eccentric positive scotoma. Patient sees all objects as through a veil, and is greatly annoyed by photopsies and scintillations, and by the perception of a bluish flame, which constantly occupies the centre of the visual field. He complains besides of the most various abnormal sensations in and around the globe, of a feeling of pressure in the depth of the orbit against the eyeball, of pains in temples and forehead, of sensitiveness to light, etc.

"The ophthalmoscopic examination reveals venous hyperemia of the retina. Optic disk is pinkish red, of somewhat indistinct tints.

"The condition of the left eye has not changed."

I operated upon the left eye in the following manner:

I made a section at the sclero-corneal border, just within the limits of the morbid changes in the iris, introduced Liebreich's iris-forceps, grasped the whole segment of the iris, which contained the "*depression and elevation*," drew it out and cut it off. No foreign body was found in the excised piece of iris. Now I again introduced a pair of forceps, caught the membrane, which covered the whole pupillary region, and managed to



remove it entirely. On inspection, a small oblong piece of metal was found imbedded in the posterior surface of the lower end of the membrane. Considerable hemorrhage followed the operation, and a few drops of vitreous escaped from the wound.

A compressive bandage was applied on both eyes.

No reaction whatever followed the operation, and the healing process took place most favorably. The bandage was removed on the third day.

When I examined the patient on the eighth day, the condition was as follows:

"Vision of the right eye 12-15; with convex 72, 12-12; Jaeger 12 is read at fourteen inches distance, with the naked eye. Subjective complaints greatly abated. No photophobia and lachrymation. Scotoma somewhat more transparent.

"The left eye shows a very fine artificial pupil. The hemorrhage in the anterior chamber is only partly absorbed. Vitreous contains blood and dense floating opacities."

This remarkable improvement in the condition of the right eye had taken place without any other influences having been brought to bear upon it but the extraction of the foreign body. I abstained from all therapeutics during the eight days, and no more forcible proof of the sympathetic nature of the affection can be adduced than the spontaneous recovery after the cause of irritation had been removed.

An alterative and derivative treatment, which I now instituted, had the following effect:

"Vision of the right eye is at present 12-8. The pupil is of normal reaction, the accommodation paralysis has greatly improved. His punctum proximum is at fifteen inches, and he reads, with the help of convex 10, the finest print (Jaeger 1) at six inches distance. The visual field is normal, and the scotoma has contracted to an oblong rod of about two inches in length and of one-eighth inch in diameter. This scotoma is transparent, and does not interfere with vision. All subjective complaints and perceptions have vanished, with the only exception of the bluish flame, which, however, but faintly and only occasionally appears in the visual field. Background of the eye is normal.

"Vision of the left eye is 1-16, and may possibly improve still more in the future. There still are large floating opacities and some bloody streaks in the vitreous. The background of the eye can only dimly be seen. There are morbid changes in the retina and choroid, due to inflammatory processes which had taken place in these parts."

You have, gentlemen, before you a case in which a foreign body had penetrated into the eyeball, causing traumatic cataract and consequent morbid changes in the ureal tract and retina. The lens is absorbed, and a thick, opaque membrane (secondary cataract) obstructs the whole pupillary region. The foreign body remains imbedded in the posterior surface of the lower end of this membrane for nine months, without doing any harm. Then the right eye begins to show symptoms of sympathetic trouble. Amblyopia and paralysis of the muscle of accommodation develop. And while these morbid changes of the most serious character take place, no inflammation proper, no objective irritation, can be observed in either eye. The injurious influences, which have continued to work for two years, are checked at once by the removal of the foreign body. The secondary affected eye makes a marvelous recovery, which far surpassed all my hopes and expectations. Such a vision as 12-8 is only met with in very rare instances; and the primary injured eye, which was not considered worth while being preserved, improves to such a degree as to enable the patient, should he have the misfortune to lose his right eye, to find his way in the streets, to recognize faces, to distinguish features, and eventually to gain a living by peddling, etc., if need should be. This case may justly be called a triumph of conservative surgery.

#### COLD WATER IN LABOR.\*

BY J. WILLIAM TRABERT, M. D.,

Of Annville, Pa.

Among the different methods to expedite labor we find very few that can really be called oxytocic. What appear to be successful in the hands of one are failures with another. Ergot had its day; in like manner came chloral and quinine, both of which have oxytocic properties ascribed to them. I have tried both. The former very often produces emesis, and in no case did it assist in dilating the os uteri; and with the latter I had not the success of Dr. Bardell, of Colorado, who pronounces it the safest and most reliable oxytocic at our command.

The only reliable oxytocic that I have found in my obstetrical practice is cold water. The attention of the profession was first called to this in 1871 by Dr. H. Garvin, of Louisville, Ky. He reported a number of cases where in the absence of ergot cold water was used with the best results; yet it appears the profession paid very little at-

\* Read before the Lebanon County Medical Society.

tention to it, for since then it is not mentioned in any of the writings or discussions on this subject that I have seen or heard.

Its efficacy in exciting contraction of the uterus in post-partum hemorrhage is well established, and its superiority over other agents in hastening labor with less danger is shown by the cases reported by Dr. Garvin, and also the following cases which I have selected from others.

Case 1. Mrs. L., aged 20, primipara. Was sent for at 11 p. m. On examination, I found the os uteri high up, hardly dilated the size of a quarter. There was scarcely an interval to the pain. I gave her chloral, which she vomited. At 7 a. m. I found no change in the os. I now resorted to cloths wrung out of cold water and placed on the abdomen, which were changed every five minutes. This immediately brought on contraction, and in fifteen minutes the os was dilated the size of a silver dollar. Labor now progressed rapidly, and at 9 a. m. she was delivered of a child having a hydrocephalic head.

Case 2. Mrs. D., aged 27, primipara. Was called in consultation at 12 p. m.; had been in labor about forty-eight hours. I found the os uteri dilated about the size of a dollar, the parts soft, the pains, although severe, seemed only to annoy her. Ergot had been given *ad libitum*, before I arrived; tried to bring on contraction by artificial means, but failed. At 4 a. m. cold water was applied to the abdomen; labor now set in in full force, and at 5:30 a. m. she was delivered of a male child. This was a case of dry labor; no liquor amnii whatever escaped.

Case 3. Mrs. B., aged about 22, also first pregnancy, under the care of another physician. Had been in labor about twelve hours. I was sent for, and found the os uteri dilated about one-fourth, the parts very rigid. Cold water was at once applied to the abdomen, which immediately brought on contraction, and in one hour she was delivered of a fine healthy child.

I think if this method was more employed we would have less rupture of the os uteri or perineum, and less post-partum hemorrhage.

I cannot better explain the action of cold water to the uterus than in the language of Dr. Garvin: "Cold, when brought in contact with the surface, though locally depressing through its communication with the nervous centres, acts as a stimulant, affecting the whole system or only certain organs, accordingly as it is generally or locally applied. All are familiar with the effect of cold water sprinkled upon the face in attacks of syncope, also its more powerful stimulant influence upon

the brain in narcotic poisoning. It does not act as ergot, producing by its toxic influence on the nervous system an abnormal and dangerous stimulation of the parts which are affected by it, but the reverse; the dormant or flagging powers are, as it were, awakened and revived to renewed action, a normal state of affairs is re-established, and the functions are carried on as they were previous to their failure."

The following is the method to proceed: The water should be cold; it is not necessary always to have ice water, as Dr. Garvin suggests, but if convenient is preferable. A towel should be dipped in it and wrung until only sufficient water remains to wet the parts to which it is applied; this should be quickly placed on the abdomen, so that as much of the cold will remain as possible; the cloth should be changed every five or ten minutes, or as soon as it becomes warm.

#### A CASE OF FRUHLJAHR-CATARRH.\*

BY HOWARD F. HANSELL, M. D.,  
Of Philadelphia.

Michael Wood, æt. 12, applied at the South-western Hospital, in the early part of July, on account of inflammation of the eyes. His father, who accompanied him, stated that every spring, as soon as the cold weather had gone, Michael's eyes began to grow red. This statement is indefinite, but, as far as I can learn, is strictly true, for its advent is simultaneous with the onset of warm weather, whether it be in March or delayed until May. The eyes slowly grew worse during four weeks, when the acme was reached. The patient should be seen in the middle of the summer; then the disease is at its height, and the eyes present a remarkable appearance. However, the fall is not yet far enough advanced to have obliterated all the characteristic signs of his affection. These peculiarities are described by Arlt in his "Klinische Darstellung des Auges," and by Saemisch in Graefe and Saemisch's "Handbuch der Augenheilkunde," in almost the same words. There is an elevation of the edge of the cornea, caused by infiltration of a gray, yellow, pulpy mass. On the limbus or margin are found small, gland-like, solid, light gray or yellow, somewhat transparent bodies, which appear on the nasal or temporal side, or both together, and slowly encroach on the bulbar conjunctiva. As they grow along the edge, they advance on the transparent part of the cornea, and are sharply lined from it, while they imperceptibly fade into the conjunctiva. They are

\* Read before the Philadelphia County Medical Society.

tough, immovable deposits, and do not yield to the probe. The conjunctiva in pronounced cases has lost its transparency, and its enlarged vessels run into the elevations on the cornea. The color of the conjunctiva differs from that of inflammation, as well as from the normal; it is steamy, dull, pale red, wanting the freshness and liveliness of acute catarrh. This is due to the light serous infiltration of the part.

This condition of the conjunctiva is called by German authors, "Frühjahr-Catarrh," and is without a name in English. The title is a bad one, because the affection is not a catarrh, neither does it exist only in the spring. It is a periodic or annual hypertrophy of the conjunctiva and the neighboring section of the cornea. An acute catarrh may be associated with it, as it was in this case during part of July. This rapidly disappeared under treatment. The hypertrophy, however, resisted all treatment. For several weeks I kept the eyes under atropia, and three times each week I applied a crystal of sulphate of copper to the lids without the slightest benefit. Since August 1, the treatment has been stopped. The disease continues to appear regularly at the beginning of warm weather, reaches its maximum intensity in four weeks, and disappears after the first snow, leaving no trace. This is repeated for a period usually of four years, although it may run on many years longer.

Treatment has little or no effect; the only references which I have been able to find are the two mentioned above, although I have searched the works of Stelwag, Carter, Schweigger, Jacobson, and Soelberg Wells.

#### FRACTURES OF ARM THE RESULT OF DELIVERY.

UNFOUNDED SUSPICION OF BANDAGING BEING THE CAUSE OF SLOUGHING OF THE HAND.

BY JOHN J. REID, M. D.,  
Of New York City.

It is important to put on record a case of sloughing of the hand occurring in a child having fracture of the arm, the result of delivery. Inasmuch as the evidence at first pointed directly to bandaging as being the cause. There was nothing of special interest noticed for several days after the injury. The arm was put up in a right-angled tin splint, and the usual means taken to keep it in place.

One morning it was found that the hand on the affected side was swollen, and immediately the splint and bandage was removed. On the follow-

ing day evidences of sloughing appeared on the back of the hand.

At this stage the feelings of the attendant were by no means pleasant, as there was but little chance left to defend the treatment of the case. But on the following day swelling occurred on the hand of the unaffected side, and on which there could be no means for any external mechanical obstruction. Within a few days the child died. There was no post mortem examination. There were no signs of swelling of the feet, or any other evidences of dropsy.

As was suggested at the beginning of the article, the record of cases of this class are very important as having a bearing on cases of malpractice.

It may be well to say that all cases of fracture of the forearm in infants are not as easy to treat as might be inferred from the reputed experience of some. The special difficulty is to obtain a splint that will prevent motion at the point of fracture. Often trying different methods, I found the only reliable way was to place a sufficient amount of cotton-wool between arm and chest to allow of the arm to rest in a slightly abducted way, and then bind the arm to the chest with a bandage. No matter what splint I used, I found that the child drew the upper fragment inward and thus caused angularity, but by packing the space between the arm and chest with cotton-wool this was prevented.

## HOSPITAL REPORTS.

### NEW YORK HOSPITAL.

CLINIC OF PROF. WILLIAM H. DRAPER, M. D.

Reported by W. H. SEELYE, A. M., M. D.

#### Fibrous Pleurisy.

Patient's name is H. V., thirty-seven years of age, a widower, a native of Germany, and a teacher by occupation. He gives no family history of any importance. Has never had rheumatism, or any pulmonary disease before this. Has never had gonorrhoea or other venereal disease. Does not drink to excess. Nine years ago he had an attack of fever and ague of moderate severity, which was successfully treated, and he has not been troubled with it since. He has never coughed up any blood. He was not taken ill until September, 1879, when he had an attack of pleurisy with effusion in the left side. For this he was aspirated, and seventy-two ounces of fluid were drawn off. He got better, but has never been entirely free from pulmonary difficulty since. But he has frequent attacks of dry, hacking cough, which come on and last for two or three weeks, and then they cease, and remain absent for about the same

period, and then return again. Sometimes this cough is accompanied by a mucous expectoration. For the last two or three months he has been gradually getting short of breath, and three weeks ago he suddenly became unusually so, and he suffered greatly from dyspnoea, and for the last two days these symptoms have become extremely distressing. During the last four days his feet, legs, and eyelids have become oedematous. During the first days of this last attack he had a diarrhoea, but since then his bowels have been regular. He did not notice anything unusual in the character of the urine. Has not vomited at all. He applied for admission to the hospital yesterday, because of his extreme dyspnoea. His pulse was at that time 112, respiration 40, and temperature 100.2°. The urine was of an amber color, an acid reaction, a specific gravity of 1.016, and contained a little albumen, but no casts, and some muco-pus.

The point, gentlemen, in the subjective history which especially interests us, is the attack of pleurisy which he had in September, 1879. That was evidently an acute attack of pleurisy, and it was relieved by aspiration. He then made a good recovery from his acute troubles, and went to work again. But the history since that time is the history of many patients who have suffered from acute attacks of pleurisy. He did not get entirely well, and ever since then he has had repeated attacks of cough, in connection with difficulty of breathing upon exertion; and the lung which was compressed by the effusion and the inflamed pleura never entirely recovered their functions, and the lung has been constantly more or less embarrassed, and this embarrassment was increased by such circumstances as exposure to cold and over-exertion, which tend to congest the lungs.

This attack, which began three weeks ago, was not accompanied by any chill or other marked symptoms. He was only unusually short of breath; but this had been coming on for several months. Since this attack began, he has had some new symptoms, showing that the pulmonary circulation has become so embarrassed as to cause some embarrassment in the return venous circulation. This is shown by the occurrence of oedema in the feet, legs, and face. We will therefore go directly to the chest for the objective signs which will explain the subjective symptoms.

As I expose the chest the first thing you notice is a faint macular eruption scattered all over its upper portion. This is the peculiar eruption of a disease of the skin, which is called in the books *pityriasis versicolor*, an eruption which was formerly supposed to be the result of a constitutional disease, and therefore the patient on whom it was found was made the victim of an active course of constitutional treatment. But a few years ago it was found to be due to the development in the horny layer of the epidermis, of a parasitic plant or fungus called the *microsporon furfur*. It is a very difficult affection to get rid of, but it is not of much importance for it never invades the face, and is usually confined to the trunk.

*Inspection.*—There is marked flattening of the chest under the left clavicle. The left shoulder is a little lower than the right. On the back there is a distinct falling in of the chest walls at the

outer side of the left scapula, and in the axillary line. There is a marked difference in the curve of the two sides of the chest, and the angle of the curve is much more acute in the axillary region on the left than on the right.

*Palpation.*—The movements of the chest as transmitted to the hand are much freer on the right side and under the right clavicle than upon the left. The abdominal muscles, the diaphragm, and all the accessory muscles of respiration are brought into play in breathing. The vocal fremitus is marked upon the right side of the chest, but not very distinct upon the left. It is more distinct in the upper portion of both sides, but is feeble low down. The apex beat can not be easily made out, but it does not seem to be much out of place.

*Percussion.*—There is comparative loss of resonance upon the left as compared with the right side. But in the precordial region the percussion sound is quite clear, while the dullness is marked above this area, and in the axillary region, and in the lower portion of the chest. Posteriorly there is dullness in the supra-spinous fossa upon both sides, but less marked upon the right. The pulmonary resonance is diminished over the whole extent of the right chest. The note is not full and clear such as would indicate a fully expanded lung. But still in comparison with the left side it is resonant. The left side is also resonant in the upper portion as compared with the lower. There is also appreciable a sense of resistance in percussing over the lower portion, which is not felt in the upper part.

*Auscultation.*—Over the lower portion of the left chest the breath sounds are absent, but they are to be heard under the clavicle, where they are modified by moist rales, both on inspiration and expiration. These sound like moist mucous rales. But let me tell you that what seem to be moist mucous rales are sometimes extra-pulmonary, and not made in the bronchial tubes; and where you think there is an excavation in the lungs because of the loud gurgling rales you obtain, you may be mistaken, for these rales are sometimes produced by dry friction sounds. It is not always possible to tell the true character of these sounds. But I am inclined to think that here they are extra-pulmonary, from the fact that he has had a pleurisy, and since then the lung has become more and more embarrassed by reason of the exudations which have taken place.

On the right side of the chest over the upper three inches I get puerile respiration, and this is very commonly found in the sound lung in patients who are suffering with pleurisy. For nature compensates, by increasing the capacity of the healthy lung, for the loss of power in the diseased lung, and hence we get an exaggerated respiratory murmur. And this is called puerile respiration, because you naturally get a louder murmur in children than in adults. As I listen lower down here, this puerile character is lost, and the respiratory sound is feeble and distant, and entirely different from that obtained above. The voice sounds are also quite distinct above, but are lost below. It is evident then that for some reason or other the expansion of the lung in its lower portion is embarrassed. Upon the back on the left side the respiration is feeble from above down to within one inch of the inferior



angle of the scapula, and below this there is distinct bronchial breathing. Upon the right side, over the upper part, the respiratory sound is somewhat exaggerated, but just below the inferior angle of the scapula it is lost, and the vocal sounds are in correspondence with these respiratory sounds. That there is no fluid in either side seems to have been proven by the fact that the doctor has obtained none by puncturing the chest. You remember that I told you the other day that puncturing the chest was a crucial test of the presence or absence of fluid in the pleural cavity. But to-day I must tell you that that statement is not always true. For in that very case, though puncturing the chest had failed to discover it, there was a pleuritic fluid, but it was confined between the meshes of an abundant fibrinous exudation which had thrown out trabeculae between the pulmonic and costal walls, and these by contracting had not only caused compression of the lung, but had also included between its meshes a certain amount of fluid, which the needle had failed to reach. Or in such a case the fluid though present may be of a gelatinous consistency, so that puncturing the chest may fail, because it will not pass through the needle. In this case both sides of the chest have already been punctured, and I should have supposed from the physical signs that some exudation would have been found within the right pleural cavity. But there was none. It would seem, therefore, that this labored breathing is due to embarrassment of the left lung from the formation of pleuritic adhesions, which also account for the deformity of the left chest. And very likely we get embarrassment upon the right side from the same cause, but the pleuritic inflammation has been a more recent occurrence. We get here the usual signs of a pleuritic effusion. But you might ask if these may not also be signs of pneumonia. If they were, there would necessarily have been a history of acute symptoms. But there is none here. He has a bronchial expectoration of mucus which contains no coloring matter, and has nothing pneumonic about it. It is due to a simple bronchitis; and a bronchial catarrh of some extent is an almost invariable accompaniment of a chronic pleurisy. I find that the heart sounds are normal. And now with the stethoscope I hear everywhere upon the right side, both in front and behind, pleuritic frictions, and therefore we have here probably a fibrous pleurisy, with thickening of the serous lining, and consequently compression of the lung tissue. And upon the left there is probably compression and condensation of the lung due to the contraction of the fibrous adhesions which bind it to the walls of the chest. And now the doctor says that in puncturing the chest the needle felt as though it was passing through a thick layer of fibrous tissue.

When this man came into the hospital he was very much distressed for breath, so he was immediately put to bed, and active measures were resorted to for his relief. Now what was the cause of this condition and of the dyspnoea from which he has suffered for the past few weeks? It was due to the fact that the lungs had become embarrassed by reason of the pressure produced by the contraction of the fibrous exudations, which caused a diminution of the capacity of the lungs.

And what happened next was, that the right heart became over-distended, and so systemic, dropsy became inevitable. This had begun at the time of his admission, and though it has now greatly diminished under the influence of rest, yet if he should get up and walk about and return to his work, or do any vigorous exercise, he would again become more dropsical from interference with the pulmonary circulation.

Now on what principles would you treat a patient whom you should see in the condition in which he was when he was brought into the hospital? Rest is the first and most important thing. For this man without rest in the recumbent posture, or in whatever position is most comfortable or gives him most relief, medicines would be of no use. So the first thing to do in his case was to put him to bed. The next thing was to try and relieve the obstructed circulation, which was manifested in the rapid pulse, the great dyspnoea, the cold extremities, and the pale face. The right side of the heart was distended, and it could not drive the blood through the lungs, while the left side was nearly empty and collapsed. So alcoholic stimulants and morphia and digitalis were administered to increase the heart's power while dry cups were also applied to the chest to relieve the congestion. Under this treatment the man was made quite comfortable within a couple of hours.

After stopping the paroxysm, you are prepared to treat the malady itself which has brought on this condition. And it is important to consider here the limits of the power of medicines. How much can you do to restore this man to a healthy condition? You cannot do much in the way of promoting the absorption of the fibrous exudations which bind down the lung. But yet you may do something to get rid of a portion of the fluid, and to check the progress of the contraction; but you cannot restore the lungs to a healthy condition. You may assist the removal of the fluid by counter-irritation, and diuretics, and by improving the nutrition; and proper exercise may then check the further contraction of the lungs. You will find that in cases of this sort an aggravation of the symptoms is often induced by a poor condition of the general system. So the patient should be well fed and nourished, and the heart should be kept as sound and vigorous as possible, and he should be instructed as to his manner of life. Therefore, it is that these patients improve under the diet and favorable conditions of the hospital. To increase the nutrition you should administer ferruginous tonics and cod liver oil, and give good food; and under this treatment they will improve faster than under diuretics, cathartics, and counter-irritants. Especially is this the case in children, where diuretics are of comparatively little importance. As you see this patient from week to week, I am sure you will note a great improvement in him, as the result of rest, food, and tonics.

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—Haig (*Practitioner*) reports at length a peculiar case of migraine, which had long resisted treatment, and was finally cured only by strict adherence to a vegetable diet. Meat seemed to act upon the patient as a veritable poison.



## MEDICAL SOCIETIES.

## PATHOLOGICAL SOCIETY OF PHILADELPHIA.

*(Continued from page 524.)*

Dr. Harris inquired about the danger of lighting up a former ovaritis by dilatation. The operation is successful, but that is its danger.

Dr. Goodell has not hesitated to operate, but always uses opium first, and by the time the operation is over the patient is under its influence. He keeps them in bed and under the opium until all tenderness has passed entirely away.

Dr. Wm. Goodell exhibited a

**Dermoid Cyst of the Right Ovary.**

A saleswoman, aged twenty-seven, was obliged to give up her situation, because she found herself unable to stand for any length of time. Her physician discovered a pelvic tumor, and called in Dr. Goodell to see her. The diagnosis was obscure, but he leaned to a fibroid degeneration of the right ovary. The woman was otherwise well, suffering no pain whatever, except when she was in the upright position. The operation was performed on September 8, and the tumor turned out to be a dermoid cyst. Being enveloped in the broad ligament, it was removed with difficulty. It is stuffed with hair and contains a plate of bone, the sharp edge of which was readily felt per vaginam; but it threw no light on the diagnosis, as it was mistaken for a fibroid spur. His patient did uniformly well, and is now out of bed. He stated that in his experience these tumors are very vulnerable and often resent even so slight an operation as aspiration; inflammation and suppuration quickly setting in. A physician had to-day brought to his office a young woman who had been tapped last June with a trocar. Long hairs and much sebaceous matter escaped through the opening, which had not yet healed up, and it was for this reason that he had been consulted. Upon passing in a uterine sound he struck a foreign body, which from its density and the sharp click it gave, he was disposed to think was a tooth. He advised dilatation of the fistulous track and the removal of the offending body.

**Two Cases of Oophorectomy.**

Dr. Goodell also exhibited the ovaries which he had removed on September 17 and 29 from two patients, who also were doing well. He stated that the amount of tissue change in these ovaries was very slight, and yet the suffering of each patient had been great. One had been an invalid for several years, and bed-ridden for the past six months. She had lost much flesh, and was always groaning from left ovarian pain, unless under the influence of large doses of morphia administered hypodermically. The left ovary was found to be undergoing cystic degeneration, but the right one was so sound that in its removal he was glad to have the backing of Prof. W. S. Playfair, of London, who was present at the operation. For he believed that in most cases needing oophorectomy the results usually showed failures unless both ovaries were removed and the menopause established. Convalescence after the operation had been retarded by great and painful swelling of both parotid glands, which developed without

any marked rise in the temperature and without acceleration of pulse, and declined without suppuration—behaving exactly like mumps. This made his third case of parotitis following the removal of the ovaries. Not one had ended fatally, and from the very slight febrile movement, he thought that the complication was not symptomatic—as in blood-poisoning—but sympathetic, and that a strong kinship, recognized by laymen, existed between the sexual organs and the cervical glands. Since the operation, all pelvic pain had ceased.

The other patient was a poor woman aged thirty, the mother of seven children. She was sent to him by Dr. George S. Hull, of Chambersburg, Pa. Three years ago she began to suffer from double ovaralgia. The pain never left her wholly, but it began to increase in severity a week before the period culminated during the flux, and faded off afterwards. Large doses of anodynes were also needed in this case, and she was unable to work. The case was clearly one of ovarian dysmenorrhea, and he believed she would be permanently cured.

Dr. Charles H. Thomas asked Dr. Goodell his experience of the result of oophorectomy. What proportion of cases are relieved?

Dr. Goodell could not reply definitely. He intends to report his cases before this society at some future time. In the majority of cases, menstruation ceases; and that element of trouble being removed, the patient is to that extent always improved. The neurasthenia resulting from previous suffering may remain, but it is far more amenable to treatment after the cause has been taken away. One such case has occurred to him recently. Dysmenorrhea caused a virtual insanity, with a mind constantly wandering. The removal of the ovaries at once cured the dysmenorrhea. The patient is now able again to walk, and the mind is improving. The operation removes the major element.

Dr. Thomas has now in his care a case which he thinks typical. The patient is a literary woman, overworked and crushed by family anxieties and depressing emotions. He prescribed rest and feeding. Massage proved of but little use, and electricity yielded negative results. Forced feeding became impossible. During menstruation she suffered for two or three hours with moderate dysmenorrhea. Signs of ovaritis developed, with swelling and hardening in the right iliac region. The patient was etherized, and a careful examination resulted in finding nothing materially wrong. As soon as anesthesia was complete, all the induration and tumefaction disappeared. There was an ulcer of the rectum, and moderate flexion of the uterus. The ulcer has since been cured, but there is no sensible relief. She suffers from a violent pain in the right ovary, extending to the coccyx and across the abdomen; it is cutting in his character at all times, and terribly severe. Formerly it ceased at night, but does not now. Hypodermic injections of morphia, night and morning, are necessary. Riding increases the pain, which often extends down the right leg. She can not sit up long without increasing the pain, which is evidently getting worse day by day. She has been totally disabled for nearly ten months. Is this pain hysterical? Can it be relieved by oophorectomy?

Dr. Goodell remarked that oöphorectomy is, in any case, a question requiring serious consideration. In the cases just related by him, the patients had neither the means nor the time for prolonged treatment. Whenever possible, everything should be tried before resorting to an operation. One bed-ridden case under his care, very analogous to Dr. Thomas's, had been relieved by the long-continued use of the constant current passed through the affected ovary. A feeble current was kept up for many hours, sometimes for a whole night at a time. The patient ultimately got well, bore several children afterwards, and is now earning her living by teaching.

**Observations from the Study of 142 Cases of Hystero-trachelorrhaphy.**

By Charles Meigs Wilson, M. D.

Though much has been written on this subject in the past two years, I trust a description of special instruments, and a summary of the history of 142 cases, will not be amiss. In view of the exhaustive treatment the subject has received in the hands of many observers, I hesitate to report my own limited experience. One hundred and four of these cases occurred in the practice of Dr. E. Wilson, two in my own, and the balance I witnessed as an assistant either in hospital or private practice. I regret that circumstances prevented me from obtaining a full history in all the cases. No one should hesitate in performing the operation, or be unable to recognize the lesion; yet very frequently gynecologists have sent to them either for an opinion or operation cases diagnosed as eroding ulcers, fungoid vegetations, cancers, etc., which, when the patient is properly examined, prove to be cases of laceration. The touch alone is sufficient to establish the existence of the lesion. If corroborative evidence be required, the patient should be placed in the knee-chest position, and the uterus exposed with a *sinus speculum*. For in this position, if each everted lip be grasped with a *tenaculum*, by gentle manipulation the natural contour of the cervix can be restored. If this simple feat can be accomplished, the diagnosis is at once established; for in malignant disease, *ulcerations* of the os, etc., this cannot be done. Reeves Jackson considers this test infallible. Formerly, many cases of laceration were comprehended under the generic term *ulcer*. But the description of the lesion and the operation by Dr. Emmet has settled forever the "well-worn controversy which so long divided medical opinion concerning the etiology and pathology of the so-called ulceration of the cervix uteri." Oftentimes useless and injurious applications are made to the cervix, because the gentlemen having the medical care of the cases do not understand that the cervix is torn. The old-fashioned tubular speculum is still too frequently used. It is now generally conceded that it is useless except where *harsh* treatment is to be applied to the cervix without injury to the vagina. The tubular speculum separates the already everted lips, and makes the laceration assume a more angry appearance. Thus faulty methods of examination often obscure the diagnosis. Another difficulty with many physicians is that the symptoms of which the patient complains are too apt to be regarded as the expression of some malady in which the

uterus is not involved—unless indeed they complain of some vaginal discharge, a condition rarely absent.

Again, the train of symptoms which belong to laceration belong equally to many other uterine ailments, and nothing but a carefully conducted examination can demonstrate that such is the case. The anæmia, debility, and other results of laceration, like the results of many other pathological conditions of the pelvic viscera, are often treated by a course of tonics, whilst the underlying cause of all the mischief goes on with its destructive work. When a woman consults a physician, complaining of any of the more marked symptoms, such as cranial, rectal, vesical, or pelvic pain, a feeling of weight about the uterus, disordered menstruation, and leucorrhœal discharge, a vaginal examination should be considered an "imperative and essential prerequisite to treatment." The test of investigators is always at hand, namely, the index finger, which, says one of the masters of gynecic surgery, "When properly educated and used to the full extent of its capability, there is hardly any of the pathological conditions of the pelvic organs in woman which can escape its detective powers."

Simpson, in England, and Gardner, in this country, first called attention to lacerations of the cervix. Emmet, as he himself says in his book, accidentally discovered the lesion in 1862, and devised the operation for its relief. To him belongs the credit of revolutionizing gynecic surgery. Parturition is the chief cause of the lesion. The pressure of the child's head alone, especially if it be a large one, upon the os, may even in a normal labor be sufficient to lacerate it. If the os be rigid, or, as frequently happens, be both rigid and attenuated, the danger is of course increased. If the longitudinal and oblique fibres of the uterus have greater contractile force than the circular fibres of the lower segment of the uterus have expansive powers, the force of the contractions of the former exerted upon the fetal body, which rests upon and is engaged with the latter, may lacerate them owing to their non-expansion. In premature labor, the circular fibres of the os not being ready for the dilatation necessary to permit the egress of the contents of the uterus, may give way, *i. e.*, there may be sufficient irritation of the uterus to expel its contents by contracting the fundus, but not enough to expand the os. Meddlesome midwifery is a prime cause—by which term I mean the practice of trying to force back from the presenting portion of the child the margin of the os, without waiting for it to dilate properly; the desire to expedite the labor in every possible way; the premature rupture of the membranes—the physician forgetting that nature's dilator, the "bag of waters," is the best of all. Experience teaches that all labors in which the membranes have been ruptured prematurely, either accidentally or purposely, are apt to be complicated by some laceration of the obstetric canal, especially of the cervix. Unnecessary and unscientific exploration of the forceps, and traction made with them without a proper knowledge of the pelvic canal and outlet, is another factor. That the forceps are responsible for many cases of laceration there can be no doubt. When applied high up or within the uterus, they

are exceedingly apt to produce tearing of the cervix.

Observations made by Dr. Munde at the Mt. Sinai Hospital, New York, showed 119 cases of laceration in 700 women examined. Dr. Hanks, of Demilt Hospital, found only eight per cent. troubled with laceration. The Mt. Sinai is a Jewish institution, and most of its patients Hebrews; these are generally attended by midwives. The Demilt is patronized by the poor of the city generally, and the patients are mostly attended by young graduates, who frequently use the forceps. As far as these observations go, they show that the forceps, even in inexperienced hands, do not do as much to produce laceration as the often untimely interference of ignorant midwives. Prof. Gross, in one of the last papers he ever wrote, spoke of the frequency with which the forceps were applied, strongly condemning this practice, and very justly attributing many of the cases of laceration of the cervix to it. He formulated his views in the words, "the principal causes of laceration are precipitate labor, labor attended with rigidity of the mouth of the womb, and instrumental labor."

Dr. Fundenberg, in an article which appeared in the *Pittsburgh Medical Journal*, makes use of this positive language: "I believe that the forceps, when properly applied, is a preventive of laceration of the cervix." \* \* \* When carefully introduced for instance into a rigid os, dilated only sufficiently to receive a narrow blade, the waters being discharged, it preserves the cervix, by its inclined plane, from sudden impulse, and simulating the bag of waters in its wedge-like and outward action, it dilates with great and continuous power, with any desirable amount of slowness, and with very great safety. In the 142 cases seen by the writer, the forceps had been used in 49—presumably from the account of the patients at the labor, from which their distress dated.

Did space permit, I should like to quote from other papers in reference to this question. Suffice it to say that the maladroit use of the forceps is responsible for many cases of laceration. The breech presentation is another factor, because of the necessity of rapidly delivering the head. The cervix may also be torn by the shoulders after the head has passed safely through. The injurious practice of giving large and frequent doses of ergot prior to the expulsion of the fœtus is another cause. So too are abortions. The predisposing causes include the various forms of induration, whether caused by hyperplastic deposit or malignant disease: all affections of the cervix producing tissue softening, such as epithelioma, or any condition interfering with the natural elasticity of the part, as the cicatrices of previous surgical procedures, or as happened in two of the cases the writer saw, of cauterizations, and any syphilitic or strumous taint giving the uterus lack of tone. T. E. Wilson lays great stress on the "muscular depravity," the result of a constitutional syphilitic taint, and the consequent emaciated condition of the os. This muscular degeneration may be the result of many pathological conditions—for example, anæmia, malnutrition, phthisis, and the like.

Again, when the uterus is in a state of constant activity, owing to frequent gestation, it is liable

to lose tone, and thus pave the way for the exciting cause to light up the trouble. Women are more apt to meet with this accident at the time of their first delivery than subsequently. It occurs, also, more frequently in rapid labors. Dr. Emmet believes that partial laceration takes place at the first delivery. Dr. Goodell, Dr. Pallen, and Dr. Munde, all record it as being exceedingly common. In two hundred women with uterine disease examined by the writer, nineteen had laceration of the cervix. The lacerations may extend through any portion of either lip. The writer has found the bilateral to be the most common—the rent being greater upon the left side—and laceration through the posterior lip the rarest form. The fact that a laceration has taken place is seldom noticed at the time of its occurrence. When an examination is made at the completion of the delivery, the parts are so enlarged, soft, and yielding, and the os so patulous, that it is difficult to detect a laceration. But if a tear has occurred, the woman soon begins to complain of symptoms which are well nigh pathognomic. Shortly after she rises from her bed and resumes her ordinary household duties she notices a more or less constant and generally increasing leucorrhœal discharge. This discharge is thick, viscid, and glairy, and sometimes tinged with blood. Sometimes, though rarely, this discharge is absent, or, after a time, disappears. Pain is a prominent symptom. It is generally of a dull and aching character. It is frequently referred to the lumbar region. Headache is a marked symptom. There is a peculiar sense of weight about the uterus, which is increased along with the pain after exertion. This feeling is augmented when the woman assumes the erect posture. The menstrual flow is, as a rule, increased. It is profuse, longer in duration, and comes on at shorter intervals. There is generally a nasty, glairy, and sometimes semi-purulent discharge during the catamenial intermission. My own observation has taught me that there is generally an increase in duration and amount. When the laceration is recent, the increase is so small that it is hardly noticed; but, as a rule, it increases steadily, until it sometimes assumes the character of a sudden and violent uterine hemorrhage. Patients generally suffer with a feeling of malaise. The general health soon becomes impaired. The digestive system is often the first to suffer. Sexual appetite is usually impaired, sometimes abolished, its gratification always attended with great pain. Insomnia is often present together with other symptoms of a nervous character.

The writer has seen one case in which hystero-epilepsy was a prominent symptom. The symptoms are usually commensurate with the extent of the eversion of the lining membrane of the cervical canal. This membrane when thus exposed loses its delicate epithelial coat, and it chafes against the posterior wall of the vagina. This irritates and inflames the raw surfaces. Hypostatic congestion and engorgement ensue. This prevents proper involution of the uterus, and the parts remain enlarged and soft. The heavy uterus, inadequately sustained by its supports, falls to the floor of the pelvis, dragging the upper portion of the vagina with it. This makes the cervix look elongated, when in reality it is short.

ened. Sometimes cicatrization takes place, and often this plug of cicatricial tissue gives rise to symptoms more distressing than when the parts remain ununited. The mental symptoms are sometimes very grave, amounting to such a degree of mental perturbation as to threaten the sanity of the patient. One of Dr. E. Wilson's patients was for some months in an insane asylum. After her cervix was restored her symptoms gradually subsided, and eventually, in the space of six weeks, entirely disappeared. This woman was deprived of her liberty because her friends refused to have the operation done. Another woman in his practice, a subject of melancholia, with uterine symptoms, came very near being 'played'; after her cervix was repaired her melancholia and other symptoms vanished entirely.

A very curious case of persistent salivation apparently due to laceration, at all events which was cured by restoring the cervix, is reported by Dr. Longyear in vol. xvi., No. 1, of the *American Journal of Obstetrics*. Did space permit, I might cite other interesting cases.

If the foregoing views in reference to laceration are correct, the indications for treatment are certainly clear. Having decided to resort to surgical means for the relief of his patient, the surgeon must consider whether the patient is in a proper state of health to operate. The same conditions which militate against other surgical procedures, are equally operative in cases of trachelorrhaphy. When the uterus is bound down by adhesions or severe inflammation exists, it is dangerous to operate. One case which came under my observation nearly perished from an attack of peritonitis, because forcible traction was made to draw down to the ostium vagina a uterus which was fixed and immobile, owing to adhesions, the result of a former attack of peritonitis.

For operating, the patient should be placed in the dorsal position, with her buttocks well down down to the edge of the table, an assistant taking charge of each limb. The cervix is exposed with a Sims' speculum, grasped with a volsella, and gently brought to the ostium vagina. The needle is passed through the cervix in the median line from above downwards. It is then armed with a stout piece of silk cord and withdrawn. A blunt-pointed tenaculum is then passed up the cervical canal until it engages the cord, a loop of which is withdrawn. This loop is divided and united to each free end, thus forming two loops, the one controlling the anterior the other the posterior lip. The margins of the tear are now freshened, care being taken to extend the line of incision beyond the angle of the rent, and to cut out any cicatricial tissue that may be present. The hemorrhage, which is never very profuse, and which by depleting the vessels of the uterus, tends to ameliorate the inflammatory conditions often present, is easily controlled by the application of hot sponges.

Any one who has seen many operations, must have noticed the sudden blanching and softening of the cervix due to the bleeding attending the operation. The late Prof. Gross thought that the result of the operation was largely due to this local depletion. I have seen the circumflex artery cut on several occasions, but it never required a

ligature to control it. Care should be taken to make the posterior angle of the plug of tissue removed sufficiently acute to allow of the proper approximation of the lips without tension in the sutures. The lower lip should be denuded first, otherwise, the hemorrhage will obscure the field. Sufficient mucous membrane should be preserved in the centre to reform the canal. This is not always possible, and when it can not be done, a small piece of carbolized lint should be inserted to prevent union in the line of the canal. This should be removed at the end of twenty-four hours, otherwise the canal may be occluded. This accident happened in three of the cases of Dr. E. Wilson's series, and the occlusion was overcome with some difficulty. All clots having been removed, and exact hæmostasis having been maintained for some moments, the wound is closed by inserting the needle through both lips, arming it with a wire suture, withdrawing it, freeing the wire, and clamping it with a shot. The ends are then cut off close to the shot. The sutures should be removed by the tenth day; as they are difficult to get at, these scissors were devised for that purpose. The vagina should be syringed twice daily with a solution of the mercuric bichloride  $\frac{1}{2000}$ . A Sims' speculum should be used to remove the stitches, as there is danger of tearing the freshly united surfaces apart with a bivalve. In three cases I have seen excessive bleeding, all occurring on the third day after the operations. This, however, did not seem to come from the wound, but was regarded as the result of a passive congestion of the endometrium. If the operation is successful the relief afforded is speedy and sure, and what is more generally permanent. The operation is simple and free from danger. It often renders sterile women capable of child-bearing. Dr. E. Wilson has confined ten women on whom he had previously performed the operation. In two there was a slight recurrence of the tear. In many cases where coitus was impossible on account of the pain and hemorrhage it produced, the difficulty has been entirely overcome. In one case only did the operator fail to get a satisfactory result. The cervix was badly torn. It was repaired. The woman was afterwards found to have salpingitis. Though her health improved after the restoration of the cervix, she did not recover.

In a future communication to the society I hope to show her fallopian tubes. Allowed to run its course, the sequelæ of laceration are endless. Disturbances of the catamenia, dysparania, ovaritis, leucorrhœa, subinvolution, grave mental disturbances, and above all epithelioma.

In conclusion, gentlemen, permit me to quote the words of a distinguished gynecologist, "These are no longer the chimeras and hobbies of the specialist, but grave and serious dangers." It is to be hoped that in time to come, a more scientific and certain knowledge of the dangers and difficulties of parturition, and the means for their avoidance, may enable physicians to avert the accident.

Dr. Baer inquires if the operations were done for the relief of sterility.

Dr. Wilson replied that they were for the relief of general symptoms. Ten of Dr. Ellwood Wilson's cases have since become pregnant.

Dr. Goodell remarked that he had no trouble



in removing the stitches. His method was to leave the two lateral upper stitches with long-shotted ends: by means of these each side of the cervix can be drawn into the field of his bivalve speculum and the stitches removed with ease.

Dr. Montgomery bore testimony to the same, and to the value of the bivalve speculum over the Sims's for that purpose. He had used the double thread through the cervix, and had described its uses before this Society at the meeting of October 6, 1881, and published in full in the *Obstetric Gazette*, January, 1882. As regards the quantity of tissue to be removed in closing a laceration, the operator must be governed by the character of the injury, and it might not be possible to have a satisfactory result where there was an anteversion of the uterus, the flexion occurring in the lower part of the cervix, the anterior lip being elongated and hypertrophied, the posterior normal or even atrophied, for in such cases it was impossible to prevent the preponderance of tissue in the enlarged lip. He could readily understand that such a uterus becoming pregnant, in the subsequent labor the long anterior lip would form a segment over the child's head, which would almost certainly result in relaceration. In the case which Dr. Wilson cites of extensive laceration during labor, the proper treatment would have been to perform a primary operation by the immediate introduction of sutures rather than permit her to be subjected to the necessity of a secondary operation. It would be necessary to introduce the sutures much deeper and then to make allowance for the subsequent involution.

It is not infrequent that multiple lacerations resemble epitheliomatous disease, and are accompanied by offensive discharge. He had given temporary relief in such a case by the use of chromic acid and tannin locally. The needle used in passing sutures should not be much larger than the wire that is to follow it.

Dr. Wilson questioned the propriety of primary operations on the cervix, and thought the weight of authority against it.

Dr. Montgomery remarked that the first case by Montrose Pallen was a primary operation, and was successful.

Dr. Chas. H. Thomas remarked that at the meeting of this society held October 6, 1881, he had reported a case of

#### Laceration of Cervix Uteri Simulating Cauliflower Excrescence,

which he had treated eighteen years before. The patient was exsanguine from hemorrhage, which had put her life in great danger. He used glycerole of tannin tampons and at the end of two weeks she had improved immensely, and the condition finally proved to be a deep laceration with ectropion. Before the treatment she had been seen by six experienced gynecologists, who declared the condition cancerous and one of them refused to be convinced that it was not so, saying within the last four years, that "it had been cancer, it was cancer, and she would die of cancer." When the case was reported, another of the physicians who had originally seen the case inquired of Dr. Thomas if he "proposed to cure uterine cancer by means of glycerole of tannin tampons." The menopause has since been established; the uterus examined within the past month was

found atrophied, and the former patient has been for nearly twenty years a hard-working monthly nurse.

Dr. Goodell thinks it pardonable to make the mistake. With all his experience he had seen two cases in which he could not for some time make a certain diagnosis. There was no doubt about the existence of a laceration, but whether the angry-looking growths were merely coxcomb granulations or epithelioma was not so easy to decide. They eventually proved to be benign.

#### PHILADELPHIA COUNTY MEDICAL SOCIETY.

##### Discussion on *Fruhjahr-Catarrh*. (See p. 546.)

Dr. E. O. Shakespeare: I have seen this affection a few times. It is one which I have supposed to be peculiar to the spring of the year, having in my mind two cases that so occurred, but I have seen one which appeared semi-annually. As to the pathology, I am at a loss to form an adequate understanding.

Dr. Sajous: I would like to know if there was much pruritus?

Dr. Hansell: These cases occur very rarely in this country. Dr. Harlan, to whom I sent the case, in his many years of clinical experience at Wills' Hospital had never seen a single instance of it. Neither have I been able to find any reference to it among American writers. In answer to the question as to its connection with hay fever, I may say that this disease has a different history and pathology, and in the reported cases has been associated with no other affection. It bears a closer resemblance to pterygium than to any other eye disease.

##### Discussion on Case of Removal of Foreign Body from the Eye. (See p. 543.)

Dr. E. O. Shakespeare: This is a case of more than ordinary interest from many aspects, and Dr. Landesberg has rightly called it a triumph of conservative surgery. It is well known that a foreign body may remain in place many months or years before showing sympathetic irritation. The whole case, while an illustration of the benefits of conservative surgery, also shows the advisability of gaining the patient's consent to enucleation, if necessary, before the search has been begun. These cases may, however, cause, in the minds of the laity and members of the general profession, erroneous impressions of the absence of danger from foreign bodies in the eye.

Dr. Roberts: We should give Dr. Landesberg great credit for his acumen in supposing that he could remove the foreign body. I always warn patients who come to me with lost vision from bodies in the posterior portion of the eyeball, of the danger of future sympathetic ophthalmitis, advise them to have enucleation performed, unless they live in the portions of the country where skilled ophthalmologists are found. This case will incline me to make exploratory procedures before enucleation.

Dr. W. S. Stewart: What was the nature and size of the body?

Dr. Landesberg, in closing the discussion, said: I take exception to the practice of all those surgeons who resort, without further delay, to enucleation in instances of injury to the eyeball with



loss of vision. In all cases in which there is no foreign body in the interior of the globe, we have to abstain from operative interference, and watch the eye with care. There is no danger in waiting. Sympathetic irritation is not likely to occur immediately after the injury. Enucleation itself is not so harmless as it is generally represented in text-books. It may sometimes give rise to sympathetic irritation, and I would impress this fact upon the general practitioner. It is not indifferent to the patient whether his blind eye is removed or not. A blind eye looks, in the greatest majority of cases, better than the artificial one, and we have to give to the patient the benefit, as long as it is compatible with the safety of the other eye. It is a matter of aesthetics. If a foreign body has penetrated the eyeball, the first indication is to remove it with an electro-magnet. If it cannot be found, and there is traumatic cataract, I would at once remove the latter—the body may be imbedded in it. Should this removal fail, I advise enucleation at the same sitting. The foreign body extracted in this case was about 3 mm. long, and of metal.

#### Discussion on Method of Curing Crooked Noses.

(See page 467.)

Dr. Jurist: I have been so unfortunate as to have operated on a few cases of divided septum, but generally found that after two or three months the septum had returned to its former position. I

hope Dr. Roberts will state whether his cases remained permanently straight.

Dr. Roberts: If free incisions are made, the deviation ought not to return. If, after operation, the parts are held in place two weeks, the chances are that they will remain in the new position as surely as after the original accident.

Dr. Jurist: I would not like Dr. Roberts to understand that I did not fracture the septum. I do so in all cases—using the stellate punch—and do not rely simply on a plug.

#### Discussion on Case of Poisoning by Soothing Syrup.

(See page 469.)

Dr. Joseph D. Schoales: I remember a similar case—a child sixteen months old—with which I sat, up a whole night. It recovered under a treatment for opium narcosis. In another child, five months old, the symptoms resembled those produced by a teaspoonful of laudanum. Fifteen drops of the syrup had been given. Neither case case resulted in death.

Dr. Hirsh: I recall a case in which trouble and annoyance had arisen from a physician's prescription being marked "poison" by the druggist. This occurred after the recent fiasco in which such notice was ordered in each case by the coroner's deputy, an interpretation of the State poison law since reversed by the court. An explanation was necessary before the patient consented to take the medicine and the physician back into the family.

## EDITORIAL DEPARTMENT.

### PERISCOPE.

#### A New Fever—"Abilene Fever."

Dr. Peyton Turner, of Abilene, Texas, thus writes in the *Texas Courier-Record of Medicine*, September, 1884:

About twelve months ago I began to meet with a peculiar form of continued fever in my practice, and after diligent investigation I was constrained to pronounce it a new disease. It was of so frequent occurrence I began to need a name for it, and in lieu of no name I began calling it the "Abilene Fever" last summer, not knowing it was prevalent in any other portion of the State. Numbers of cases of it have fallen under my observation lately, and by this time it is tolerably well known in this city as the "Abilene Fever." I was called several weeks ago to see a little girl who had been sick several days, and her parents told me they could not break the fever with quinine, and they were afraid she was taking the Abilene fever. It so happened that their fears were not unfounded, as it proved to be this fever and lasted several weeks. Her little brother has contracted the disease also, and is at present sick.

To all practitioners who are desirous of familiarizing themselves with this disease or its symptoms, I would advise them to peruse carefully the able article in the *Courier-Record of Medicine* (July number) by Dr. Wilkinson, of Galveston. He describes so faithfully the symptoms that I feel incompetent to add or take from. However, I

humbly beg to differ with him and Dr. Stout, of Cisco, in regard to the term "catarrhal," as applied to this new fever, for I do not consider that name as throwing any light on its pathology whatever, and I am disposed to regard this term in the light of a misnomer. I would not like to have this disease called the Abilene fever, for obvious reasons, but I would be glad to have some appropriate name given it, as it is as likely to become a disease of the future as any other zymotic disease.

So far as my observation has extended, I claim now, as I have for more than twelve months, that it is a new disease; notwithstanding I get the name of being a *Smart Aleck*, as a result for promulgating my views on this important disease. I regard this new fever as being caused by a specific poison conveyed by means of the atmosphere, and like other specific diseases, self-limited. It is not contagious, or but slightly so. It has a predilection for the summer and fall. It prefers for its victims the younger class, and both sexes suffer in about equal proportions. The liability to the disease greatly diminishes after twenty years of age; from three to fifteen are the ages most susceptible to the disease. It is sometimes associated with malaria; this latter element is easily eradicated by quinia, but quinia has no influence on the disease *per se*. Sweating seems to be a permanent feature in some cases; the extremities are cold as marble, and yet have a temperature of maybe as high as 101°. Mildness of the attack characterizes some cases; and diarrhoea,

when present, is sometimes extremely hard to control; in fact, it seems also self-limited, resisting such measures as opium, kino, catechu, bismuth, pepsine, iron sulphate, copper sulphate, etc., for several days, and then gradually getting better. Some cases are remarkably exempt from typhoid symptoms, even when the disease persists three or four weeks, though there are exceptions to this rule. It bears a tolerably close resemblance to relapsing fever. Its mean duration is about twenty-one days.

I regard the mild and persistent elevation of temperature, muscular pains, cold or cool extremities, sweating, etc., the most prominent diagnostic symptoms, naming them in the order of their relative sequence, and then if quinine proves of no utility I regard the diagnosis as highly probable. Dry, hot weather favors the production of this fever; it has no important sequelae, but convalescence seems to be rather tedious. As to whether one attack gives immunity from subsequent attacks I am unable to say, though it is more than probable, as in cases of zymotic or germ diseases. This is a highly important point yet to be decided, and it is to be hoped that physicians throughout the State will contribute articles on this fever for publication in the *Courier-Record* from time to time, that we may prove a mutual benefit to each other, and by this means become more thoroughly acquainted with the disease and its management; and indirectly, to the use and benefit of mankind.

As regards its treatment I would humbly call the attention of the profession to the supposed value of arsenic in large doses. I administered 10 gr. of liq. Fowleri three times daily (or its equivalent; according to age,) in four cases, with marked benefit as regards the general condition; and if the stomach is too irritable I give half the quantity, but twice as often. Quinine does no good in this fever, but I think arsenic is deserving of further trial; in fact, I put another case on the arsenic treatment this day, after treating the case tentatively a week.

#### Bouton de Gafsa.

In *Lyon Méd.*, Ed. Boinet and Ch. Déperet tell us that this is an exotic cutaneous disease belonging to the same nosological category with the eruptions known as "Clons de Biskra, Laghouat des Zibans, Boutons du Nil, d'Alep, de l'Inde," etc. On account, however, of its comparatively harmless character and short duration, it will here be considered as simply a mild form of the latter affections.

Bouton de Gafsa recently made its appearance as an epidemic in the military camp at Sathonay, whither it had been imported from the south of Tunis by a battalion of returned soldiers. We thus, as army surgeons, enjoyed an opportunity—the only one hitherto afforded in France—of observing its progress and development in over forty almost simultaneous cases.

The course of the malady comprises the four stages of induration, ulceration, desquamation, and cicatrization. It commences with the appearance of a small, red, hard, and indolent tubercle, which never assumes the character of a vesicle or of a pustule, and lasts from one to two weeks. A process of exfoliation then begins at the apex of

the tubercle, whence the epidermis is detached in large, white, dry, and very thin scales, and gradually extends, not only over its entire surface, but also downwards, as far as the deeper layers of the derma, where thicker scales are formed with a slight serous exudation. This period is usually very short, but in some cases may last two or three weeks. It is succeeded by an ulceration of the derma, producing large dry crusts of a deep-brown color. The tubercle now flattens down into the semblance of a turtle-shell, having an average breadth of three or four centimetres. As the ulceration proceeds, this crust loosens and falls off, leaving a perpendicularly excavated sore, with jagged edges and a livid base, which discharges pus or blood. This process may involve the subcutaneous cellular tissue, but never extends further. The duration of this stage is about five or six months. When healing commences, the discharge becomes less abundant; then the crusts fall off, leaving a granulated surface, like a simple sore, with slight tendency to cicatrization. At the end of five or six weeks the scar is fully formed. It is of a brown or purple color, with whitish streaks, and sometimes remains visible for over a year.

A spontaneous arrest of the disease is liable to take place at any one of the above-described stages, giving rise to peculiar symptoms, from which several varieties of more or less importance have been formed, such as the "abortive," the "desquamative," the "crusty," etc.

In the majority of our cases, only one or two tubercles were produced, and their number never exceeded twelve.

The parts chiefly liable to be attacked are those which are usually or most frequently uncovered, as the hand, wrist, neck, and face.

As to treatment, only one out of the many methods which we essayed proved of positive efficacy. This was the actual cautery, lightly and repeatedly applied, at a red heat, to the base of the ulcer, after the crusts had been removed by means of poultices or of local bathing.

The etiology of this disease, like that of its kindred affection, Bouton de l'Inde, is still involved in obscurity. Its contagious character was evinced in the case of a soldier at Sothanay, in whom the complaint was developed without his ever having quitted France.

With the view of testing its transmissibility by inoculation, we instituted a series of experiments in the medical laboratory at Lyons, whose results are briefly presented in the following conclusions:

1. Bouton de Gafsa, which prevails endemically in the south of Tunis, is probably contagious, and is certainly inoculable in human beings. In the cobaye, its inoculation produces a variety of morbid symptoms; in the rabbit, and especially in the horse, the process gives rise to an ulcer, bearing some resemblance to the original disease.

2. This inoculation may be successful either with the lymph, the crusts, or the successive culture fluids.

3. The eruption is not caused by a dermatophytic vegetation, as was asserted by Vandyke Carter in the case of the Bouton de l'Inde, and by Weber in that of the Clou de Biskra, but rather by a bacterium (micrococcus), which can be isolated by cultivation, according to the method of Pasteur.

**A New Plan of Operating upon Meningocele.**

Dr. Noble Smith thus writes in the *Lancet*, September 20, 1884:

Congenital hernia of the membranes of the brain has hitherto been a very unsatisfactory deformity to deal with. Almost every child so affected has died early, whether subjected to operative treatment or not. Injection of iodine into the sac has been the least unsuccessful operation tried, and Dr. Morton's iodo-glycerine fluid is doubtless the best form in which it can be used. The risk, however—one may almost say the certainty—of any fluid thus used passing into the cavity of the skull, is a serious objection to the means of treatment; and were it not for the fatal nature of the affection when left to itself, surgeons would probably seldom venture to operate upon the subjects of it at all. I have devised a plan by which the risk of the injected fluid passing beyond the sac is reduced to a minimum, and I will now describe the only case upon which I have yet operated in this manner.

C. H., aged fourteen days, was sent to me by Dr. Fancourt Barnes, from the British Lying-in Hospital, in January of the present year. The sac was formed of healthy skin, and could be emptied by pressing its fluid contents into the cavity of the skull, a proceeding which caused the infant to cry. I exhibited the child at a meeting of the medical society on February 11th. With regard to the treatment, I tried in the first place the effect of pressure. I made a cast of the tumor, upon which was moulded a piece of gutta-percha. From February 1st the pressure was gradually increased until March 31st, when, finding no improvement had taken place, I resorted to the following operation: The sac was emptied by pressure, and its two sides held together between my finger and thumb. My intention was not to inject into the cavity of the sac, from which the fluid would have free access into the ventricles of the brain, but if possible to inject into the wall of the sac close to the lining membrane. I used a hypodermic injection syringe and pierced the sac as it was held between my finger and thumb, directing the point just to one side of the median line. The latter

line would, of course, represent the cavity of the sac, which for the time being was obliterated. I must have penetrated very near to this cavity, but did not pierce it, for upon injecting the fluid there was considerable resistance to its entry, although I had ceased to hold the sac, and the latter had refilled. If the needle had penetrated the sac, the resistance would have been certainly slight, and the after-effects might have been severe. I could only inject a few minims of iodo-glycerine (about eight); the child cried, and continued to evince symptoms of discomfort for the next two hours, when he fell asleep, and subsequently awoke seeming to be quite comfortable, and remaining so. Upon April 15th I injected the tumor again in the same way. On April 23d the child's general health was good, the tumor felt firm, as if it was consolidating; I therefore ventured to pierce it to the centre with the needle, and injected more iodo-glycerine. Upon May 1st I found that no bad symptoms had followed the last operation, the tumor was feeling firmer. I repeated the injection on May 14th, and again on June 15th; upon the last occasion I left at least

twenty minims in the center of the tumor, which was a larger quantity than I had hitherto used. On July 14th the child was quite well, the tumor was contracted to a flattened, corrugated mass of skin, and the case cured.

By injecting into the walls of the sac we not only prevent the iodine from entering the cavity of the skull, but we also attack more directly the part which we wish to influence—namely, the sac, which we wish to contract.

**A Case of Extra-Peritoneal Rupture of the Parturient Uterus.**

Dr. G. E. Goodfellow reports this case in the *American Journal of Obstetrics*, September, 1884:

Mrs. C., aged 39, was taken in labor with her tenth child on Nov. 30, 1883, at 8 o'clock p. m.

I saw her first about one hour later. Examination disclosed breech presentation with feet down close to the buttocks, back to the R. acetabulum. Temperature not taken, pulse 100 to 110 and small. The pains were regular, between five and ten minutes apart, but, as the patient described them, of a peculiar lancinating character.

Her sufferings were apparently so great that the use of chloroform was commenced and continued until after delivery, which was accomplished with the blunt hook early on December 1st.

There was no hemorrhage—the placenta following the head immediately. She rested well until early on December 2, when symptoms of peritonitis supervened and death ensued on the morning of the 3d.

Post mortem showed a transverse rupture of the cervical portion of the uterus on the right side, above the vagino-uterine junction, about two inches in length and a large hemorrhage in the cellular tissue of that side extending into the iliac region beneath the peritoneum which only covered the upper half of the uterus.

There was no blood in the abdominal cavity, and the peritoneum was not torn. Near the fundus the uterus was thick and firm, but in the cervical region and near the os internum, the thickness was from one-quarter to one-half that above, and the tissues were softened.

The noteworthy points of the cases were the extreme rapidity and smallness of the pulse, 100 to 120 and more, from almost the beginning of labor; the apparent severity, and towards the last the length of the pains, with their regularity and inefficiency.

The child was a female, weighing over ten pounds. The position of the feet was, as stated, close to the nates, but not crossed, and the right foot was in a state of extreme dorsal flexion which might possibly account for the delay in the labor independently of the rupture.

During the night there was vomiting of a greenish-yellow fluid, particularly worse about the time of delivery.

The most difficult point to determine is the period of time at which the rupture occurred. From a consideration of the symptoms, I conclude that it happened or began shortly after the commencement of the labor, for then the pulse, rapid and small as it was, increased its rate, and the suffering from the uterine contractions was referred more to the right side. That it did not happen during delivery I am positive, though consider-

able force was used, still not as much as in many other preceding cases. The rapidity and character of the pulse, the intense and inefficient pains with the vomiting during the course of the labor, makes the diagnosis of rupture in the early stages certain.

I would add that while these symptoms were noted and commented upon, only a suspicion of the possibility of such an accident existed until after the post-mortem.

When the hook was applied the child was dead, and the breech just distending the vulvar opening, where it had been wedged for about three hours. No ergot was given until after the delivery.

#### A New Method of Treating Sprains.

Dr. Thomas L. Shearer thus writes in the *Lancet*, August 9, 1884:

Every one who has had sprains to treat in practice must have been at times annoyed by the slowness of recovery of the injured part. This is not so important in hospital patients, many of whom, enjoying the life, diet, etc., of these institutions, do not object to prolonged treatment; but in the wealthier classes in private practice the surgeon must often hear complaints that the injury is so long in recovering. I have had a considerable number of sprained limbs to treat, and, after employing the usual plans of treatment, was led to adopt a new agent—clay. The clay is simply that used for making bricks, free from gravel, dried, and finely pulverized in a mortar. The powdered clay is mixed with water so as to form a thick and moist consistence. This is spread on muslin to the depth of a quarter of an inch, and applied entirely around the part. Over this is placed a rubber roller bandage, just lightly enough to keep the dressing from shifting and to retain the moisture. At the end of twenty-four or thirty-six hours the dressing must be renewed. It may be well to relate a few cases by way of illustration.

Case 1. Mr. T—, aged fifty-eight, was thrown from his carriage, and, in addition to other injuries, received a severe sprain of his ankle, completely incapacitating him from motion of any kind. The part was hard, swollen, intensely painful, and throbbing. The dressing, as above described, was applied, and in twenty-four hours the pain was almost entirely gone, and the swelling to a great degree had subsided. The dressing was renewed daily, and in eight days the patient was going about attending to his business. The part was free from pain and natural in every respect.

Case 2. Mr. McC—, aged sixty, slipped and sprained his ankle so severely as to confine him to bed. The treatment was the same as that employed in Case 1, and the patient was out and walking in the streets in ten days.

Case 3. Mrs. A—, aged seventy-four, in stepping from her carriage missed her footing, and twisted her left knee violently. In a few hours, the part was greatly swollen, hot, throbbing and painful; the least motion of the joint caused excruciating agony. Pressure over the ligament was especially painful. Next day, I saw the patient, and applied the clay dressing. The day after, the patient was much easier, the swelling rapidly subsiding. The pain was almost *nil*, and movement of the part was not followed by such

distress. The lady was walking in her house in ten days after the injury.

Dr. Hewson, of Philadelphia, about ten years ago, introduced earth as a means of treating fibroid tumors of the uterus, and also sprinkled burns with the dry earth, claiming that the tendency to deformity in the latter cases was lessened. However, I am not aware of sprains being previously dressed with clay, and it was thought as well to lay the efficacy of the method before the profession. A number of other cases could be cited, but they would simply be a repetition of those already mentioned. While speaking of clay, it would, perhaps, not be amiss to state that the powdered dried earth sprinkled on the surface of an ulcer, and adhesive straps applied over it, is a capital dressing for cases which are so weak that even the weakest ointments tend to break down the granulations.

## REVIEWS AND BOOK NOTICES.

### NOTES ON CURRENT MEDICAL LITERATURE.

—The address on ophthalmology by Dr. W. S. Little before the Pennsylvania State Medical Society, makes a neat reprint of 20 pages. The subject is the value of pupillary symptoms in general disease.

—A thorough paper on branchial cysts of the neck, by Dr. N. Senn, of Milwaukee, goes very fully into the treatment of these troublesome and unsightly growths.

—The third number of the quarterly entitled *Drugs and Medicines of North America*, published at Cincinnati by the Lloyds, is on our table. We cannot but admire the painstaking thoroughness with which it is being conducted. No expense appears to have been spared in its production, and a deal of good enduring science is found within its covers; but there is on the other hand much that can have no scientific or practical value whatever. Pages of what has been written concerning hydrastis in this number, belong quite as appropriately to the region which produces it as to the drug itself. Workers, as a rule, may well be spared such portions. Life is too short for even what we are obliged to look over. The facts, however, as they bear upon the healing art are well stated. The illustrations are good, and those of Mrs. Stowell are especially valuable in this connection.

### BOOK NOTICES.

**Obstetric Aphorisms for the Use of Students Commencing Midwifery Practice.** By J. C. Swaney, M. D. Eighth edition. Philadelphia, P. Blakiston Son & Co., 1884.

Swaney's *Aphorisms* has long been a popular manual with students, and it certainly must



meet their wants, for here we have the eighth edition, which is saying a great deal for a medical work. It owes this to the clearness and completeness of the author's instructions. He has the happy faculty of saying a good many things in a very few words. Hence, though his volume is small, the instruction it contains is extensive. It has a number of illustrations, and is well printed.

**Lectures on Some Important Points of the Surgery of the Urinary Organs.** By Sir Henry Thompson, F. R. C. S., etc. Cloth, 8vo., pp. 146. Price, \$1.25. Philadelphia, P. Blakiston Son & Co., 1884.

The first of these lectures is upon the operation of internal urethrotomy for stricture of the urethra; the second on digital exploration of the bladder and its results; the third on tumors of the bladder; the fourth, impaired vesical function and its consequences; and the remaining two are devoted to lithotomy and lithotripsy.

They are all, as we may expect from such a writer, of the first order of importance, and full of practical suggestions. In several respects the author's practice differs widely from that most in vogue. To take one example, he urges the habitual use of the catheter in vesical catarrh, contrary, as he acknowledges, to the opinion of many eminent surgeons.

The most important part of the book is that on the operations for stone. The author having operated more than 800 times speaks from experience, and an experience whose results have been most carefully collated. His selection of operations and defense of them will be found replete with information about this serious undertaking. In fact, there is no lecturer on surgery better worth listening to than Sir Henry Thompson.

**Myths in Medicine and Old-Time Doctors.** By Alfred C. Garratt, M. D. Cloth, 8vo., pp. 242. New York, G. P. Putnam's Sons, 1884.

It is a matter of regret that so little attention is paid in medical education in this country to the history of our science. The past of medicine is scarcely ever referred to by our instructors. In anxiety for the new, the old drops into unmerited neglect. Yet it could teach many a useful lesson, and guard us against many a folly.

The work whose title we give above is an exception to this too general neglect of the lessons of past ages. It comes to us with the flavor of thoughtful erudition, with the ripeness born of long acquaintance with the ancient masters of medicine, and with the wise sayings of the sages

of yore. Those readers who hitherto have found no interest and no instruction in the study of the history of medicine should buy this book and read it, and we promise them they will discover both in its charming pages.

The author sets out to tell the history of medical schools in a series of true stories, in a few brilliant biographical sketches, and in the description of some of the delusions which at times have gained the credulity of the public. He tells of the eminent physicians between Hippocrates and Galen, of medicine in the Dark Ages and at the revival of learning, of the old notions about nervous diseases and their treatment, of alchemy, and winds up with a scathing review of the pretenses and origin of homœopathy. This last is about the most destructive to whatever claim it may yet have on scientific consideration which we have seen.

The literary finish of the author's style is most agreeable, and he may be congratulated in having developed the picturesque and captivating side of his subject, without sacrificing the accuracy of the historian of science.

**Lectures on the Principles of Surgery.** By W. H. Van Buren, M. D., LL. D., etc. Edited by Lewis A. Stimson, M. D. Cloth, 8vo., pp. 588. New York: D. Appleton & Co., 1884.

Dr. Van Buren was a very eminent teacher of surgery, and what he wrote for the press always at once took the position of a standard authority on its subject. But these lectures he did not prepare with the intention of printing them, but solely for use in oral delivery. We do not think he would have wished them published, and we fear they will prove disappointing to his admirers. We say this, because we class ourselves among them, and they have disappointed us. They lack the freshness and individuality which stamp his other works.

It is true, as the editor says, that they present the doctrines of surgery in the manner he thought best for oral delivery, but for that very reason they are certainly not in the style he preferred for a treatise.

There is, of course, much in them which it is instructive to read. That goes without saying. Dr. Van Buren neither spoke nor wrote without imparting valued instruction. His lectures were far better than most that one hears. But on the whole we fear that most reader familiar with his other works will lay down the volume with a feeling of disappointment. The book has no index, and a very inadequate table of contents.



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**THE NEW ANTI-PYRETIC, KAIRIN.**

Many reports have of late been published concerning the anti-pyretic effect of kairin, and the most recent investigations have been duly recorded in this journal. Most of these researches, however, were based upon clinical observations alone, but Prof. E. Maragliano, an author who, by incessant toil and ingenious studies has obtained the reputation of undoubted reliability, has now thoroughly investigated 1, the biological effect of kairin; 2, its action in fevers, and the laws governing its effect in this respect; 3, its dose; and 4, its therapeutical value (*Centrbl. f. d. Med. Wissensch.*, Sept. 27, 1884). M. gained the following results.

Even when administered in the dose of eighty grains, kairin does not only not cause a diminution in the arterial pressure, but increases it. The sphygmographic curve is not altered under its influence. The frequency of the pulse always diminishes by 6-18 beats per minute.

Half an hour after a dose of kairin has been given to a patient, the remedy appears in the urine; within eight hours most of it has been excreted in this way; but even after thirty-six hours some traces of it can still be discovered. During the action of the remedy the quantity of urine excreted augments.

The frequency of respiration diminishes, a peculiar burning is felt in the nose and in the eyes, the fall of temperature, caused by kairin, is accompanied by sweating and the increase of temperature, observed when the effect of the drug ceases is ushered in by a chill.

Nervous symptoms are but seldom noted; at times epileptiform convulsions appear, cyanosis is always noted in patients, to whom kairin is administered on account of its anti-pyretic effect, but never in healthy persons, and gastric disturbances show themselves only after large and frequently repeated doses, and even then they are rare.

In healthy individuals, even if sixty to eighty grains are given internally every hour, no decrease of temperature takes place. Concerning the effect of kairin in persons suffering from fever,

a large series of observations led to the following results :

Kairin can cause the highest temperature to decline to the normal, a fall of  $6^{\circ}$  to  $8^{\circ}$  being a common occurrence.

This effect commences in the first half an hour, reaches its height within from one to two hours, usually continues for two hours, and may last six hours. The anti-pyretic effect of kairin is proportionate to the thermal resistance of the patient. This law is explained by and based upon these facts :

a. In one and the same individual the same doses, administered on the same day, or on two different days, show different action upon temperatures equally high.

b. This difference in the action of equal doses evinces itself in individuals who are alike in weight and strength, and who suffer from the same high temperature.

c. In the same patients equally high temperatures are differently influenced by equally high doses of kairin at different times of the day, and experience has demonstrated that the effect of kairin is more decided in the forenoon than in the afternoon.

d. The same dose has an effect the greater, the higher the temperature at the time of the administration of the drug, and the less, the lower the temperature.

e. In different diseases the effect varies also with the same doses.

These observations prove that the antifebrile effect of kairin depends in its degree upon the greater or less power of resistance of the respective organism against the anti-pyretic action of the remedy, and that it is independent of the thermometrical height of the fever ; the power of the drug is exerted according to laws not yet determined. By thermic power of resistance is understood the faculty of the febrile temperature to resist the action of an anti-pyretic. With reference to this thermic power of resistance the size of the dose has been determined.

. Single doses of five grains cause a decline of

but one-half degree of temperature and no gastric trouble.

2. Doses of ten grains at the most reduce the temperature two degrees.

3. Doses of sixteen grains may depress the temperature from two to four degrees, and can, therefore, even in high fever, produce perfect apyrexia ; they rarely induce gastric disturbances.

4. Higher doses highly irritate the stomach and are not advised.

The minimum dose may be said, therefore, to vary between five and ten grains ; the maximum dose is sixteen grains.

To determine at what intervals the doses have to be administered, the accumulative effect of kairin had to be studied, and M. found that the highest effect is obtained by giving hourly doses until the full action is obtained. In longer intervals the temperature is not reduced to the normal. As a rule, if the temperature is more than  $101^{\circ}$ , sixteen grains ; if below that, five to ten grains are administered. The temperature has to be measured every hour, for according to the effect obtained, the next dose is determined. As soon as apyrexia sets in, kairin is no longer given, until the temperature again ascends. Within fourteen hours 160 to 190 grains have been administered ; even 280 grains have been thus given (in divided sixteen-grain doses) without any but favorable effect.

The best way of administering the drug is in wafer or cachet ; if the stomach rejects it, it may be employed subcutaneously, for which purpose sixteen grains are dissolved in the same or in double the quantity (better) of distilled hot water ; this solution must be used warm, and must not be permitted to cool. Hypodermically applied, the effect of kairin sets in earlier and lasts longer than when given by the mouth. Half the internal dose generally suffices for subcutaneous medication, though in very high temperatures the full dose may be needed. The remedy causes no more inconvenience, if hypodermically employed, than other drugs do ; the only objec-

tion to this method being the necessity of frequent repetition, as the remedy has but a transient effect. And yet, how many a valuable life would have been saved if the temperature could have been reduced to the normal for but a few hours every day? In this respect, kairin is an invaluable drug. All observers agree that it never fails to bring the temperature down to the normal, if employed as above indicated.

There are no counter-indications against its use, except irritability of the stomach. In these cases it has to be employed subcutaneously.

The great value of Maragliano's work rests in the observation which he made that kairin does not diminish the arterial pressure. Had it done so, it would have become useless and dangerous, but as it is, it can be employed with safety in any case.

#### A NEW VIEW OF INEBRIETY.

A novel and curious study has been published in a late number of the *Alienist and Neurologist*, by Dr. T. D. Crothers. Assuming that inebriety is a disease, he inquires whether it belongs to the class of contagious disorders. More correctly speaking, he asserts that it does belong to them, and gives a number of cases establishing his views.

Certainly he renders such an opinion plausible, and thus offers new suggestions for the prevention of this melancholy condition.

The instances he adduces are such as have generally been set down to the evil effects of bad example and association. Dr. Crothers very pertinently asks whether they may not be the result of an actual contagion, resulting in pathological changes of the nerve centers, and leading to inebriety with as little volition on the part of the sufferer, as if he had an attack of measles or typhoid fever.

Any observer of men will have noticed how much more liable to excess drinkers are in some company than in others, and this by no means always in the company of those who themselves are given to excess. It is often seen that the presence of some individual will be the sign for moderate drinking to be pushed to intoxication,

although such individual himself may not set the example, nor join in the drunkenness.

Whether this influence, the reality of which cannot be doubted, is mental or physical, or a little of both, may be disputed. Dr. Crothers considers it wholly physical, as must all that school of psychologists who refuse to discriminate between mental and cerebral action.

At any rate, the prolonged efforts of those who insist on following out the theory that drunkenness is a vice, a sin, that must be met by moral suasion, prayer, and sermons, have clearly shown themselves to be inadequate to meet and check this growing habit. It is therefore high time that it be encountered with other weapons and from a different point of attack. If it is accepted as a real disease, communicated like many other diseases, to be systematically treated like them, and those afflicted with it to be placed in the same category as others subject to a malady, in this instance a contagious one, then we have new resources at our command which may give us the advantage in the hitherto unequal conflict.

#### THE CHOLERA AT PARIS.

All the world feels a personal interest in the appearance of the cholera at Paris. At first it was as usual—concealed and denied. But the rapid increase of the plague in the past few days, however, has been so great that no further deception was possible, and the facts were at last reluctantly stated. Medical experts assert that they do not fear an epidemic during the winter months, but they now believe that the disease has been planted so deeply that it will live until the spring, when it will probably break out in its worst form.

Of course, business of all kinds suffers, and especially that dependent on tourists. The proprietors of the large hotels complain that their guests are leaving them so rapidly that they will shortly be without customers, and the wires are busy with telegrams cancelling engagements for apartments which have been secured. A general gloom seems to have settled over the usually careless and gay habitues of the boulevards, and con-

denunciations of the inefficiency of the government are heard on all sides. A full realization of what a fearful epidemic next summer means seems to have taken possession of the popular mind, and a state of depression exists which can only be compared to that of the dark days of the Commune.

The disease appears to have been introduced by infected rags, and to have found a congenial nidus in one of the habitats of the *chiffonniers*. The chief centre is a vile little street running out of the Faubourg St. Antoine, about half way between the Bastille square and the Place de la Nation. The earliest deaths were almost entirely among the rag-pickers. In this little street there are fifty-eight rag-houses and thirty-three saloons of the lowest description. Thus far there has been no panic among the poorer classes, but it is said that many of the wealthy guests of hotels are leaving. The poor people are now suffering so much from want of work, low wages, and dear bread, that they will scarcely mind the added evil of cholera.

Now that it is once in Paris, we need not expect that it will be permanently checked by the winter cold. It will probably remain until next summer, when that great city will be lucky to escape the scenes of Toulon, Marseilles, and Naples.

## NOTES AND COMMENTS.

### The Results in Some Surgical Cases.

Dr. H. S. Cunningham reports the following practical cases in the *Canada Medical Record*, September, 1884:

1. Gustav Jonas, æt. 12, was kicked over the left eye by a horse. The skull was crushed in. I removed the pieces, leaving an irregular opening about the size of a silver twenty-cent piece. The membranes were intact, the wound heals kindly. There was no elevation of temperature at any time or delirium. He was about in ten days.

2. Mr. J. F., a carpenter by trade, in a fit of emotional insanity cut his throat with a draw-shave. I saw him three days after his attempted suicide; the trachea was almost entirely severed at the third ring from the cricoid cartilage, and the œsophagus was cut into on the right side, sufficient to admit of the spurting forth of a small stream of water at every effort of deglutition. I

closed the wound with silver wire, and he completely recovered.

3. John Johnson, æt. 5, inhaled a grain of corn into the trachea. I operated upon him, assisted by my friend, Dr. Max Schiller. He recovered in three weeks.

4. Mrs. C. Hoffman, æt. 78, came under the care of my friend, Dr. Max Schiller, for strangulated femoral hernia. Taxis failed in reducing it. We operated, and returned the gut, but failed to return a large portion of the omentum. We cut off a portion, twisted the vessels, sponged it off, used carbolic spray, and returned it. The patient recovered in six weeks, and is well to-day.

5. Mrs. L. Hoff suffered from femoral hernia for some years, but never wore a truss; she finally had strangulation, and suffered from great distress and vomiting for twelve hours before calling for medical aid. Dr. W. B. Fletcher, present Superintendent of the State Insane Asylum, assisted me in the operation. She was attending to her household duties in three weeks.

6. Shortly after returning to the United States from Montreal, Canada, a young lady, Miss M., called upon me to remove an unusually long steel hair-pin from the bladder. She acknowledged having introduced it accidentally through the urethra while masturbating, she using the rounded end; the pin slipped from her fingers in her excitement. I was compelled to cut a small opening through the vagina and bladder to remove it. She recovered in two weeks.

7. Louisa Rapp, æt. 10, was accidentally shot, the calibre being 22; the ball entered the brain at the union of the occipital and parietal bones—crown of the head. She was shot whilst stooping, the ball ranging backwards and towards the cerebellum evidently, from the position of both parties. The membranes, as well as the tables of the skull, were perforated; she only remained in bed five days, and in-doors ten days. She never had any elevation of temperature, no vomiting or convulsions, and to-day—two years after the injury—she is enjoying good health.

### Power of Absorption Possessed by the Stomach.

From a series of observations made by Dr. C. Quetsch (*Berl. Klin. Woch.*, 1884, No. 23), to determine the power of absorption possessed by the mucous membrane of the stomach, the following results were obtained. On account of the ease with which iodide of potash is generally absorbed and demonstrable in the urine, this drug was selected for the experiments.

The healthy stomach absorbs most readily when

empty. Very little of the remedy enters the circulation if administered at the time when digestion is going on. The longer a time has elapsed since the meal, the more active is the absorbent power of the stomach. In cases of gastric catarrh, especially if accompanied by dilatation of the organ, absorption is greatly diminished. Of any drug administered immediately after a meal, most of it passes off by the bowel, very little entering the circulation. Even if the stomach be washed out after a meal, the power of absorption is nihil. The least is absorbed if the drug be given immediately after breakfast, while before breakfast, therefore, if given fasting, the power of absorption is greatest. Remedies in general are absorbed the more rapidly the longer the interval since the last meal. In cancer of the stomach, the iodine appeared several hours later in the urine than is normally the case (when its presence can be demonstrated on an average twelve minutes after swallowing), while in ulcer of the stomach the rapidity of absorption was so much increased, that the urine passed five minutes after the administration of the dose already contained the iodine.

It may be that these observations may be of some assistance in the diagnosis of certain doubtful gastric affections. They surely teach us to administer any remedy, whose rapid absorption we desire, half an hour before a meal, and not, as is often done, immediately or one, or two hours after a meal.

#### Icteric Typhoid.

Towards the end of June, 1883, in the city of Torre Annunziata, several cases of acute jaundice occurred. The cases became more frequent, and the local medical men differed as to the nature of the disease. The provincial Council of Health was, therefore, petitioned to name a commission to investigate the disease, which was described as *icterus gravis*, or as acute yellow atrophy of the liver, as icteric typhoid, or even as yellow fever. *Post mortem* examination of several bodies showed hæmorrhagic spots, acute tumor of the spleen, slight enlargement of the liver. Bile flowed easily into the duodenum; Peyer's patches were rather tumid; the cortical substance of the kidneys was somewhat congested and colored by a greenish pigment, pulmonary hypostasis, etc. Evidently the disease was an infective fever of not well-determined type, having as its prevailing symptom hæmatogenic jaundice, and probably typhoid in nature. The disease did not acquire a contagious or epidemic character. There were

only twelve cases in the course of four months in a town of 25,000 inhabitants. Of the twelve cases, seven were fatal. According to Hirsch, this bilious typhoid has been often observed on the southern and eastern coasts of Europe, and in the islands of the Mediterranean. Dalmatia, Greece, Constantinople, and Asia Minor have at various times been visited by it. A few years ago a similar outbreak occurred in Ancona. As to the etiology, no specific cause could be found; but the unwholesome state of the town is enough to account for anything. The drinking water is brought to the city in an open aqueduct, into which is thrown every sort of abomination; the subsoil is saturated with filth; the houses are dirty; there are no means of isolating the sick; and no disinfection of places or dead bodies is practised.

#### Gastrostomy for Stricture of the Œsophagus.

Since it is not always an easy matter to decide when this serious operation will be advisable, it is well to note the following advice, which Dr. John Fagan gave the British Medical Association (*Brit. Med. Jour.*, October 4, 1884):

1. In cases where the obstruction is partial, it should not be entertained in non-malignant cases so long as a bougie can be passed, or a tube worn to enable the patient to take sufficient nutriment. But should the passing or wearing of an instrument cause great irritation, while the difficulty in overcoming the obstruction is increasing, the operation may, I think, with justice be undertaken; for by it the affected parts are placed in a state of physiological rest, which tends not alone to the improvement of the part, but renders it more amenable to other forms of treatment.

2. In cases due to malignant obstruction, where the dysphagia is becoming both painful and more marked, if the permanent wearing of a tube cannot be tolerated, there should be no time lost in performing a gastrostomy.

3. In cases where the obstruction is almost complete, and where in non-malignant cases bougies cannot be passed, and before the patient becomes too much exhausted and the digestive functions vitiated, the surgeon is fully justified in urging the operation.

4. In cases where complete obstruction has existed for a short time, the patient's strength being fairly sustained by enemata, and there is no malignancy, the operation may be undertaken with hopes of improvement; in malignant cases, at this stage, it should not be urged.

5. In the advanced stage of complete obstruction



tion, no matter what the cause be, the operation should not be undertaken, for the patient, if he survive the immediate shock from it, cannot live more than a few days, that are passed in increased discomfort.

#### Specimens from a Case of Cut Throat.

To a recent meeting of the Medico-Chirurgical Society of Edinburgh, the president (Dr. Littlejohn) showed the parts from a case of cut throat. It happened in the person of a constable who had been troubled for about six months with insomnia. One morning he got up about four after a restless night. His wife, who was sleeping in another apartment, heard a heavy fall and a deep moan, and going in found her husband lying on the floor and blood flowing from the neck. Strange to say, he was able to articulate, and said he had cut his throat. His larynx was opened into, the epiglottis cut across. No important vessel was wounded, but there must have been considerable hemorrhage. He was taken to the Infirmary, but died on the way. The body was taken home after two days, when the widow consented to have a post-mortem performed, the reason for this being that the man was insured, and he (Dr. Littlejohn) was of opinion that if an autopsy revealed cerebral disease, the medical attendant was entitled to give such a certificate of death as would cause even those insurance companies who forfeited the policies of suicides to pay the policy. In this instance, he was glad to say, he found traces of chronic cerebral disease, great adhesions of dura mater to bone, adhesions in arachnoid cavity, a large amount of sub-arachnoid fluid, and roughness of the internal surface of the cranium, justifying him in giving a certificate of chronic cerebral disease with a wound in the neck, which was available in procuring the insurance money.

#### Oakum as a Surgical Dressing.

For burns and scalds, Dr. Robert Esler regards oakum as invaluable. It may be applied, he says (*Brit. Med. Jour.*, October 4, 1884), to the granulating surface with impunity, and it is more easily detached than almost any other dressing. The healthy effect of this tarry substance, when applied to the mucous membrane of the vagina, is most marked; unhealthy discharges are absorbed, and a tonic effect produced. In cases of prolapse and other displacements of the uterus, when it is difficult or impossible to get pessaries to relieve, you can secure twenty-four hours' respite to your patient by filling the vagina with oakum; and, by dipping your first plug in gly-

cerine, you gain immensely in cases of subinvolution, from the quantity of fluid extracted from the parts.

"To briefly sum up," says Dr. E., "oakum is a clean, handy, healthy, and cheap dressing. It is easy of application, and I think it is antiseptic in the sense of forming a barrier to the ingress of germ-like bodies to the part to which it is applied. Tar is in itself a good, wholesome agent, a substance of complex composition. It contains creasote, turpentine, paraffin, and eupione, and is obtained by the destructive distillation of *Pinus Sylvestris*. Carbolic acid has largely taken the place of this cruder compound; but Dr. Whitla says that there are virtues possessed by tar which are not equally enjoyed by its more fashionable rivals. In oakum we have a form of tar-dressing which I heartily recommend to those engaged in hospital work."

#### Prophylactic Measures Against Diseases of the Respiratory Tract in Children.

From the *Archiv. f. Kinderh.*, we learn that Zinnis, who is the director of a hospital for newborn children at Athens, finds that the greatest mortality among children under his charge is caused by diseases of the intestinal tract, and next on the list come those of the respiratory. He considers that the cause is two-fold—the first having reference to the climate, and the second to faulty hygienic conditions by which the children were surrounded when with their parents. A series of rules which he published containing "advice to mothers," has the following directions:

1. During cold and damp weather children should not be taken out of doors; they should be suitably clothed, and should wear woolen shirts.
2. When in the house they should not be exposed to draughts of air.
3. The underclothes should be frequently changed.

Under the author's observation, the systematic use of woolen shirts among hospital children has effected a decided diminution of the mortality from diseases of the respiratory tract. He is not in favor of cold baths before the sixth year. Other vigorous hygienic measures involving a certain degree of exposure should be deferred even to a later period.

#### The Application of the Antiseptic Method to the Treatment of Croup and Diphtheritic Angina.

Renon (*Gazz. di Med. Publica*, April, and *Gazz. Med. Ital. Prov. Venete*, May 10) has been trying the use of inhalations of carbolic and salicylic

and benzoic acids in the state of vapor, and not as pulverizations. The latter are somewhat difficult of application, and often cause a harmful chill, and they probably do not reach the ultimate parts of the air-passages as is desirable. The author places the patient in a moderate-sized room, heated to about 26°C., with good ventilation. Over a fire or lamp a vessel, containing about two litres of water, is heated, and the antiseptic is added from time to time. The apparatus should be near to the bed, and the vapor kept near the patient by a suitable arrangement of curtains. The formula he adopts is the following:

B. Carbolic acid,	280 grammes.
Salicylic acid,	56 grammes.
Benzoic acid,	112 grammes.
Rectified spirit,	468 grammes.

Every three hours a tablespoonful of this solution is added to the boiling water. This quantity generally suffices; in two cases symptoms of carbolic poisoning appeared, when, of course, the strength must be lowered. When tracheotomy has been performed, besides keeping the patient in the antiseptic atmosphere, Renon places before the cannula a loose bit of carbolized wool, fixing it with a carbolized bandage. His results are—angina diphtheritica and croup with tracheotomy, seven cases, seven cures; six cases without tracheotomy, six cures; three successful cases of diphtheria without laryngeal complication.

#### Stigmatum Maidis in Diseases of the Heart.

The *London Med. Record*, August 15, 1884, tells us that during the past three years Dupont (*Centralbl. für die Gesamte Therapie*) has employed this extract in heart diseases with very good results. The extractum stigmata maidis reduces the action of the heart and increases diuresis. It is, as a rule, well tolerated. As a rule, its diuretic action is manifest on the first day after it is administered, and not unfrequently this action increases until after the third day. The amount of water excreted often increases from 500 grammes to 1,500 and 2,000 grammes (Oj-iv). It is especially indicated in diseases of the heart with œdema of the lower extremities or general hydrops, in which class of cases it displays its power as a diuretic. As the œdema disappears, the blood supply throughout the system is better regulated; the pulse-beat is more regular, the heart's action is slower and more rhythmical. While the general condition of the patient improves rapidly, dyspnoea does not seem to be influenced by the medicament. In cases of hypertrophy, contractions, and insufficiency, the same

results were always noted. The reason why this drug deserves praise is because it is well tolerated by all the patients. When compared with digitalis it acts more rapidly, while there is not so much difference between its action and that of convallaria majalis. In the beginning Dupont always administered the drug alone, until he had carefully studied its action, after which he combined with it bromide of potassium, iodide of potassium, and milk. With regard to the dose, the largest amount given was 3 grammes (45 grains), three times a day, one hour before each meal, with a little syrup. Generally half this quantity was sufficient to bring about a diuretic action.

#### Peculiar Effect of Thoracentesis.

After a small opening had been made into the left side of the chest on account of empyema, and after the pleural sac had been thoroughly washed, the patient, a man æt. 24, began to suffer from emaciation and paresis of the left arm (E. Weill, *Revue de Méd.*, 1884, 7). A year later the same individual underwent once more the same operation, and half a year later a third operation was performed, this time a part of a rib being resected. Two days after the last operation, chorea-like movements attacked the left arm, and ten days later also the left leg. Emaciation and paresis of both left extremities developed themselves synchronously, the left thumb and adjoining fleshy part became hyperæsthetic, and the rest of the left hand evinced paræsthesia on touch, while the leg showed no disturbance of sensation.

Similar cases have previously been recorded. As it is a common occurrence to observe emaciation and paresis in cases of localized chorea following an injury or a surgical operation, especially in the beginning of the disease, it is probable that the emaciation and paresis, which after the first opening of the pleural cavity attacked the left arm, were already accompanied by choreic movements, which were so mild as to escape observation. We incline the more to this view, as in these cases the chorea is generally very mild, and because emaciation and paresis alone have, as far as we know, not yet been observed to follow the operation of thoracentesis.

#### Rupture of the Sigmoidal Flexure During Birth.

In the *Wien. Med. Blätter*, 1884, No. 23 and 23, Dr. Ed. Zillner reports four cases of new-born children, that had survived up to fifteen hours, and where the sigmoidal flexure was found to be torn. The tear was nearly an inch long, the mar-

gins of the wound were swollen, and signs of peritonitis were noted. The place is too high up for the nozzle of a syringe to have reached it, and no force used in the extraction of any of the children could have possibly caused the rupture of the intestine.

Dr. Z. tries to explain the accident by contending that the parts of the mother exert a pressure upon the abdominal wall of the child, and fixate the sigmoidal flexure, which is filled with meconium and forced backwards into the pelvis. In case the pressure increases to such a degree, that the intestine is immovably compressed between the lumbar part of the spine and the abdominal wall, the meconium can neither pass to the descending colon nor escape into the rectum, and in such a case but a slight increase of pressure suffices to cause a rupture of that part of the bowels. Z. has demonstrated the possibility of inducing the rupture in this manner upon a number of dead bodies of infants.

#### The Dose of Potassium Iodide for Children.

In the *Archives of Medicine*, October, 1884, Dr. E. C. Seguin has a very valuable article on iodide of potassium, in which occurs the following :

"Influenced no doubt by the extraordinary susceptibility of little children to opiates, many practitioners give them altogether too small doses of many remedies. This is notoriously true of the bromides, and I am sure is also true of the iodide of potassium. For threatening conditions of cerebral disease, meningitis, syphilis, etc., if we decide to give it we should administer it almost in adult doses. In cases of basal meningitis with neuro-retinitis, and in some other cases, I have given from 4. (60 grains) to 8. (120 grains) three times a day to patients between four and eight years old, not only with good results as regards the cerebral symptoms, but also without iodism or gastro-intestinal irritation."

#### The Treatment of Migraine.

In the *Brit. Med. Jour.*, June, 1884, Dr. J. K. Spender adds a few remarks to the treatment set down by Dr. Beale, in his book on *Slight Ailments of "sick headache."* Dr. Spender speaks from personal experience, and says that he always felt particularly well on the day before an attack; this warned him, so that at bedtime he took a mild aperient of aloes and myrrh, and kept off sleep as much as possible, considering a long and deep slumber as most injurious. Starvation is a rule absolutely to be obeyed, but tea may be

taken hot and strong at frequent intervals. With regard to medicines, Dr. Spender lays special stress on prophylactic treatment. A dose of Indian hemp and quinine, taken every night during the intervals of the attacks, gradually alleviates the disease. In several cases also, hyposulphite of soda has seemed to do good.

#### Iodoform in the Treatment of Gout.

Testa, in a preliminary note in the *Gazz. Med. Ital. Prov. Venete* for May 31, 1884, draws attention to the good effect of iodoform in gout. Moleschott has already employed it as a topical application in this disease with great advantage, but Testa recommends its internal administration, and this because iodoform, according to the researches of Fubini and Spallitta, accelerates tissue metamorphosis and increases the daily quantity of urea. Iodide of potassium they find, contrary to the opinion generally held, retards tissue-change and diminishes the quantity of urea. Testa, by experiments on a healthy man, confirms the views of Fubini and Spallitta, and finds moreover that, contemporaneously with the increase of the urea, the uric acid is diminished.

#### Phosphorus in Tubercular Disease.

Dr. Thorowgood, in the *Brit. Med. Jour.*, June, 1884, writes that he has employed phosphorus, as well as the hypophosphites of potash and soda, with much success in cases of pleuritic thickenings. The author states that old-standing consolidations of lung that have existed for one, two, or three months, begin to move and disperse as soon as the hypophosphite of potash is given. In cases of lung-disease which are of inflammatory or exudative origin, no remedy is to compare with the hypophosphites. It is the bacillus that seems to set the phosphorus treatment at defiance; and Dr. Thorowgood notices at Victoria Park Hospital, that, just when he finds the hypophosphites most helpless, then it is that the clinical assistant finds "lots of bacilli."

#### The Treatment of Inflammation by Subcutaneous Injections of Morphia.

Dr. Kaczorowski (*Przegląd Lekarski and Vrachy*) recommends hypodermic injections of morphia, made as nearly as possible to the part affected, and repeated several times daily, as an excellent antiphlogistic remedy, especially in cases of inflammation of serous membranes. For the sake of illustration, the author quotes a case of incipient peritonite foudroyante after an operation for hy-

datids in the liver, where a part of the purulent contents of the cyst found its way into the peritoneal cavity, and where the patient recovered, in consequence (as the author thinks) of the energetic use of morphia injection; at first two centigrammes every two hours, and subsequently one centigramme every four hours being administered.

#### A New Method for the Removal of Laryngeal Growths.

In the *N. Y. Med. Jour.*, August 23, 1884, Dr. William Chapman Jarvis highly recommends chromic acid for the removal of these growths, and he concludes that—

1. Trioxide of chromium, or so-called chromic acid, is valuable as an escharotic on account of its self-limiting action.
2. It affords a safe and reliable means for the removal of large and small soft laryngeal growths.
3. It not only removes the growth, but also prevents its recurrence.
4. It is best applied fused upon a probe.
5. Its application is facilitated by an instrument devised to act as a guide, protector, and regulator.
6. Its use in the larynx is not necessarily attended with pain or spasm.
7. It offers a substitute for tracheotomy and thyrotomy, in certain cases where these measures have been adjudged necessary.

#### Treatment of an Attack of Gout.

Prof. Dujardin-Beaumez says in the *Medical News*, October 18, 1884:

To sum up then, when you are called to treat an attack of gout, you will first assure yourself of the integrity of the kidneys, then you will administer salicylate of soda in doses of from one to one and a half grammes, or, if you prefer, the tincture of colchicum seeds combined with quinine or strong tincture of aconite root. If, on the contrary, the kidneys are damaged, or if the heart seems to be degenerated, you will have to content yourselves with giving alkaline diluents and keeping the bowels open with saline purgatives; besides enswathing the affected member with wadding, around which is placed oiled silk.

#### Decoctum Limoni—An Antipyretic.

A decoction of lemons has been recommended by Tommasi-Crudelli and others in malaria, and now Dr. Lauchlan Aitkin, of Rome, in the *Brit. Med. Jour.*, Oct. 4, 1884, gives it a wider therapeutic action and says that he has had good re-

sults from its use in gastric and enteric fevers, complicated with a malarial element towards their termination and in cases that might be called typho-malarial throughout. He lays great stress on the mode of preparation of the decoction. A freshly gathered and unpeeled lemon, is cut into thin slices, which are put into three teacupfuls of water and boiled down to one cupful. This is allowed to stand over night in the open air and given the first thing in the morning, after the liquid has been separated from the rind, pulp and seeds, by careful filtration and compression just before it is drank.

#### The Rheumatic Origin and Treatment of Chorea.

It has been maintained by some observers that rheumatism is a prolific cause of chorea, and by others this view is denied. Dr. Octavius Sturges, who has made careful observations on the subject upon the cases of 219 children, tells us, in the *Lancet*, September 20, 1884, that the etiology of chorea must find some broader basis than any that rheumatism affords. He considers that rheumatism may be regarded as one amongst many agencies, predisposing to chorea. As to treatment, he seems to place very little reliance upon drugs, for he tells us that the treatment adopted was rest, bodily and mental, good food, country air, patience, and encouragement.

#### Prepuce Grafting.

The suggestion is made, in the *Lancet*, October 4, 1884, by Dr. R. Clement Lucas, that the skin removed in the operation of circumcision can be advantageously used for purposes of skin grafting, to fill large granulating surfaces left after burns. Owing to its suppleness, thinness, and vascularity, it seems peculiarly adapted for such purposes. He believes that this skin might be conveyed for some hours, without loss of vascularity, if placed in a glass bottle or wrapped in gutta percha. Of course, we must only use the prepuce from healthy children, and if a balanitis accompanies the phimosis, it must be cured before the circumcision is performed.

#### Defective Vision from Brain Concussion.

It will be of practical value to learn that in a case of defective vision traced to a concussion of the brain, from a fall on the ice, wherein many remedial measures were unavailingly tried, strychnia finally produced good results. Dr. James A. Hopkins, who reports the case in the *Virginia Medical Monthly* for September, 1884, ordered  $\frac{1}{30}$  of a grain every four hours, to be continued through



one week, at the end of which time the improvement was marked.

#### Pin Swallowing.

This feat is not uncommon among children, and it gives rise to great terror on the part of the parents. A correspondent of the *Lancet*, October 4, 1884, tells us that a boy was recently brought to him who had swallowed a pin. He ordered plenty of bulky food, such as would tend to keep the bowels somewhat inactive, and carefully avoided any aperients. Three days later, the pin was passed in a mass of feces.

### CORRESPONDENCE.

#### The Opium Habit.

EDS. MED. AND SURG. REPORTER:—

I venture to offer for your consideration my experience in the treatment of the opium habit with digitalis aided by the terchloride of gold and sodium, and the fluid extract of coca.

Digitalis we know increases the force of the heart's action by stimulating the vaso-motor nerves, at the same time decreasing the number of the heart's beats.

The action of digitalis upon the circulation so nearly approaches to that of opium that the former furnishes an excellent substitute for the latter, without that overwhelming reaction which so often follows the effects of morphia upon the nerve-centres.

It sends the blood coursing through the brain, giving it nourishment which with care can be kept up until, with the exercise of a little will power, the patient may be enabled to discontinue the use of the narcotic. I have in a number of cases given tablespoonful doses of the infusion of digitalis every two to every four hours. The terchloride of gold and sodium in one-eighth grain doses, and fifteen to twenty minims of the fluid extract of coca. This brings the pulse down, making it full and strong, steadying the heart's action. I allow the patient to take his last dose in the usual quantity, and with these remedies can keep up the same stimulation for about ten days, when the patient will leave off the use of the opium with little inconvenience, aside from the weakness and lassitude incident to the cessation of the use of so powerful a stimulant. Here the usual difficulty of weak will-power in such cases, confronts us, but when the patient possesses an average amount of self-control he will conquer the habit, as several hypodermic syringes left in my office can attest.

Respectfully yours,

Kansas City, Mo. J. D. GRIFFITH, M. D.

#### A Curious Diet in Texas.

EDS. MED. AND SURG. REPORTER:

An article of mine on "A Curious Diet in Texas," that appeared in the *REPORTER* a few months ago, has elicited quite a number of replies, one through the medium of your journal, and a number by personal correspondence. All are

Texas physicians, and all deny that such a custom as I related is practiced in their state. They all admit that occasionally a mother mumbles the food—a cracker, piece of bread, or bit of potato, then feeds it to the babe. While defending themselves against any misstatement made, all but one have done it in a kindly, professional manner. This one has been so rude, ungentlemanly and unprofessional in his language, and taken so much pains through the columns of a journal he edits to amuse the vulgar that I feel it imperative to call upon the *REPORTER* to allow me to defend myself.

Boiled down, his scientific arguments are after this manner: My article is a "disgusting and infamous lie." I am a liar and no truth is in me. If he had me down there he would have my opinion on a coat of tar and feathers.

The editor of this only PROFESSIONAL!!! journal in the State of Texas then becomes exhausted, his cussing is completely used up, and he would like to hire an adept in profanity to help him out. He finally concludes that my article is another proof that the old fires of hate still smoulder, ever ready to break out on any pretext.

My replies will be short:

1. No professional gentleman would indulge in such language as this editor uses. Such language seems to be a poor recommendation for a Texas medical college which he desires to establish (doubtless to be one of its pillars), to keep their youth from coming north to study.

2. As to the smouldering hate ever ready to burst forth, I can say, my age is 33, the war broke out in '61, the hate was engendered years before that. The old hate must have taken deep root in a boy of my tender years. I have traveled in the South, and the warm-hearted, friendly reception extended to me, did not lead me to believe that the people were "half horse and half alligator," nor even mixed with the jackass breed, but as polished as anywhere.

3. Finally, the article under my name was largely not original, BUT THE COPY OF A LETTER OF A TEXAS DOCTOR. The truth not being in me, proof can be obtained from the editors of the *REPORTER*. A certain doctor—name withheld, he is too near the tar-and-feather brigade—wrote to the *MEDICAL AND SURGICAL REPORTER* to aid him in breaking up a disgusting habit of feeding babes chewed food. The letter was given to me to reply to. If I have erred, then I have been misinformed. Any extravagant statements made, I apologize for. But here are extracts from the Texas letter before me: "I have observed on two or more occasions, but learn 'tis a common habit for mothers to chew the food for their children. In one instance in remonstrating, I made comparison to the bitch throwing up her vomit for her pups, and I must say I nearly lost my life."

He continues: "I am held in such ill-favor here on account of my remarks and comparison, please help me in your *REPORTER* to vindicate myself."

Defend truth, correct errors, Texas friends; but the English tongue is full enough to do it in pure language, and in a cultured manner, without stooping to ranting, "cussing," and tar and feathers.

C. C. VANDERBECK, M. D.

2246 Ridge Avenue, Philadelphia.

[Dr. Vanderbeck is entirely correct. The information about the habit came to us from a

highly respected Texas physician. That any Texas physician should demean himself to write profane and abusive letters is far more discreditable to his community than the habit referred to, which latter is not discreditable at all, but only peculiar, and of questionable hygienic propriety. —EDS. REPORTER.]

### The Dangers in Canned Goods.

EDS. MED. AND SURG. REPORTER:—

The denial of Gen. John P. Hawkins that canned goods are not poisonous as published in the papers for some time past, should be refuted by all authenticated cases of poisoning by such goods, as it will have a tendency to throw the public off their guard in the use of such goods which we are using for our every-day food.

We can readily account for the General's ignorance of the fact that such cases have occurred in his department, from the simple fact that an ordinary case of poisoning from canned goods, with the symptoms of purging and vomiting, would not likely be reported to the Commissary Department, even with the more aggravated symptoms of cramp both in stomach and muscles of the extremities, unless the case should have resulted in death; all of which the author of this article has experienced, except the latter. Last February, at the Ocala House, Ocala, Fla., caused by canned peas, three companions experiencing similar attacks, though less severe. How many more of the guests fell victims to the same poisoning I did not learn, as we left the hotel in the morning as soon as we were able to be moved on board of the steamer. The quality of the peas appeared good; as for quantity, we all know what the allowances are at our Southern hotels.

Since the preceding occurrence, I have had two families in my practice who have been similarly poisoned by canned vegetables put up in tin cans.

The trouble undoubtedly lies in the bad material used in the manufacture of the cans. The tin used, if tin at all, must necessarily be of the most inferior kind, on account of the very low price at which the goods are put in the market. My traveling companion, Mr. Smith, of Brooklyn, proprietor of a furnace there, informs me that they have been smelting these old cans. The fumes emanating from the furnace by the process have poisoned the people in the neighborhood to such an extent as to cause complaint being entered against them, compelling them to discontinue the operation. The reputed tin is a combination of lead, antimony, and tin, and probably some other equally poisonous conglomerations. There is no supposition about it: it is a known fact in the tin trade, and is sold cheap as such. Legislation is required to protect the public from this becoming a common every-day occurrence of poisoning by canned goods, both vegetable and animal—as much so, if not more, than to protect against adulterated food.

S. ROSENBERGER, M. D.

2260 N. 7th street, Philadelphia, October 27, 1884.

—The *Lancet* states that Prof. Huxley has been recommended to leave England, and to spend some months in perfect quiet and freedom from work. It is believed that he will go to Venice.

## NEWS AND MISCELLANY.

### Micro-Organisms and Disease.

From the *St. Louis Med. and Surg. Jour.*, Oct., 1884, we note as follows:

In an able paper on the formation of poisons by micro-organisms, considered especially in relation to the production of disease, read by Dr. Black, of Jacksonville, Illinois, in the section of Practical Medicine and Materia Medica, at the May meeting (1884) of the American Medical Association, the author arrives at the following conclusions:

1. All cognizable forms of life are dependent on the production of molecular change in matter for their continued existence.

2. Every cognizable form of life, capable of independent existence, must have the power of digestion for the preparation of food material for the nutrition of its material structure.

3. Each living cell must appropriate to its nutrition food material prepared by a digestive body of its own formation, or by the appropriation of material prepared for it vicariously by some allied living cell.

4. Every living cell must support its life and material structure by the continued imbibition, and remolecularization of matter within itself; except during the special provisions of rest, as in the seed, egg, etc.

5. Every living cell must, as the result of the remolecularization of matter within itself, form waste products of two classes; a respiratory waste product rich in oxygen, and an urinary waste product poor in oxygen. All waste products are poisonous to the form of life from which they emanate.

6. Natural organic poisons are uniformly waste products of the organisms in which they are formed.

7. Pathogenic micro-organisms, by their remolecularizations of matter, form poisons of the nature of the alkaloids, which are the active agents in the production of disease.

8. While I should not class the digestive bodies, and diastases, as organic poisons, they may act as irritants when applied to another form of life than that which produced them.

9. The normal tissues of the animal resist the invasions of micro-organisms by throwing out or forming a digestive body calculated to destroy them or dissipate and nullify their action; aroused thereto by the presence of, or the irritating agents given out by, the organisms.

### A Germ-Proof Filter.

In the *Popular Science News*, November, 1884, we read that none of the filters ordinarily employed for the purification of drinking water are proof against the passage of microbes, or the minute forms of life that are now generally recognized as playing so important a part in the causation or transmission of disease. A device for straining out these infinitesimal organisms has long been a desideratum; and we are now indebted for it to M. Chamberland, the director of M. Pasteur's laboratory. He has found that the liquid in which microbes have been cultivated becomes absolutely pure if passed through unglazed porcelain. Its

parity can be demonstrated by mixing it with liquids sensitive to the action of microbes, such as veal broth, milk, and blood, in which it produces no alteration.

The tube of unglazed porcelain is enclosed in another of metal, and the water to be filtered is admitted to the space between the two by turning a stop-cock. Thence it slowly filters through to the inside of the porcelain tube, and flows out at the bottom. Under a pressure of two atmospheres, or thirty pounds to the square inch, a tube twenty centimeters in length, with a diameter of two centimeters and a half, will yield about twenty liters (five gallons) of water daily. For a larger supply, it is only necessary to increase the size or the number of the tubes.

In cleansing the filter, the porcelain tube is removed, and the microbes and other matter that have accumulated on the outer face of it are brushed off. The tube may also be plunged in boiling water, in order to destroy any germs that may be supposed to have penetrated beneath its surface; or it may be heated in a gas-jet or in a furnace. In fact, it can be more readily and more thoroughly cleaned than most of the domestic filters in ordinary use.

#### Vanderbilt and the Cripple.

We have already noted the munificent gift of \$500,000 that has been made by Mr. William H. Vanderbilt to the New York College of Physicians and Surgeons. From the *Albany Journal* we learn that this act of generosity was caused by a small incident.

Vanderbilt stopped at a wayside inn in Upper New York, as is his custom of an afternoon, to rest his horses and take a glass of gin and water. The place is known to horsemen as Barry's, and is commonplace enough, except for being the favorite stopping-place for Vanderbilt, and for that reason a resort for the chronic roadsters. While he stood with his back to the bar, his elbow on it, and a glass of grog ("two fingers of Holland gin, two of hot water, and a spoonful of sugar"), a pitiable cripple entered—a little boy, with misshapen legs and back awry.

"How did you get into such a shape, sonny?" Vanderbilt asked.

"I was runned over," the urchin replied.

An accident on the road had special interest for the questioner, and he got the particulars. The little fellow had been overturned and trampled on by a fast horse. He was too poor to be doctored at home, and yet his mother had foolishly objected to his removal to a hospital, where he might have received proper treatment; but he had been taken to the College of Physicians and Surgeons, where applicants get inadequate attention, or only such as will serve as illustrations to the lessons which the students are learning, the facilities being so limited as to preclude anything further.

It chanced that Professor Doremus, the Professor of Chemistry, dropped into the bar-room at this juncture. In answer to the King of Mammon's question, he said it was a pity that this college had such limited quarters and scant facilities. He said that a big building would serve as good a purpose as he knew of in the whole range of New York charity. From that directly came Vanderbilt's unexpected \$500,000.

#### The Climate of Canada and its Relation to Life and Health.

At the recent meeting of the British Association for the Advancement of Science, Dr. W. H. Hingston, of Montreal, compared the French Canadian with the French of France; he was taller, heavier, and stronger than his French ancestor; the race was the "most prolific on the face of the earth," and the people did not seem to suffer by early marriages. The climate of Canada was singularly healthy, and there was no disease peculiar to the country, though climate modified the diseases common to Canada and other countries. There was an Anglo-American cast of countenance in the United States, but not in Canada. They were forming another type.

#### Items.

—The Health Exhibition which was lately closed in London shows a profit of \$150,000.

—According to the *Popular Science News*, to obviate hereditary tendency to disease in the young, "Wash them, air them, and iron them."

—It is announced that the Italian Government has ordered the building of a crematory, on the Gordni-Guzzi system, for the cholera lazaretto at Varignano.

—The *Medical Age* lays the blame of a large proportion of "malpractice suits" upon the medical colleges, for conferring degrees upon the ignorant and incompetent.

—Dr. Joseph White, of Canajoharie, N. Y., died on October 27, in the eighty-fourth year of his age. He was one of the oldest physicians, and was the oldest Mason in the State.

—The first inquiry which the International Collective Investigation Committee propose to institute is in regard to rachitis, its frequency, and the physical condition of the district in which it is found.

—At the recent meeting of the British Medical Association in Belfast, Dr. W. T. Edwards, of Cardiff, was elected President for the ensuing year, and that city selected as the place for holding the next annual meeting.

—Dr. Bell, in the *Canada Med. Record*, reports a case of aneurism in the pericardium which arose from the lower and back part of the transverse portion of the arch. The aneurism was not detected until the post-mortem.

—A bill was introduced into the New York legislature, to compel the complainants in a suit for malpractice to give bond in surety for all damages that might occur to defendant in case the complaint was not sustained. The bill failed to pass.

—On the 1st of November the Court of Appeals of West Virginia delivered its opinion that the law regulating the practice of medicine and surgery was constitutional and valid. This decision at once places the State Board of Health on substantial legal ground.

—It is announced, in Vienna papers, that the daughter of Herr Smolka, President of the Austrian Chamber of Deputies, has died from taking a quantity of an anticholeraic disinfectant, called "Antibakterion," in mistake for a mixture which had been prescribed for her.

—The value of arsenic injections into goitres has been definitely decided by Dr. Dumont, of Switzerland, as related by Jonquierè in an abstract in the *Internat. Centrallbl. für Laryngologie*, etc. He treated 26 goitrous patients thus, with no benefit whatsoever.

Professor Polk, of New York, has used hydrochlorate of cocaine successfully in two operations upon the cervix uteri. The results in these cases look toward an extensive usefulness of the new anæsthetic, not only in gynecology, but in many of the minor surgical operations.

—The *Union Médicale* learns that, in consequence of the death of M. Moreau, M. Jules Falret, physician to the Bicêtre, has been transferred to the Salpêtrière, and that M. Charpentier, adjunct physician to the Salpêtrière, has been appointed physician to the Bicêtre.

—Professor Widerhofer (*Allg. Wein. Med. Zeitung*) recommends traction of the tongue, and sprinkling the face with cold water, during an attack of laryngismus stridulus, and in the intervals bromide of potash—four grains night and morning, gradually increasing to eight grains.

—The *Lancet* learns that Professor H. Kronecker, of Berlin has accepted a nomination to the chair of physiology at Berne, succeeding Professor Grütznér, who goes to Tübingen, and that Professor Hermann, of Zürich, is to take the same chair at Königsberg, succeeding Professor von Wittich.

—The *Paris Conseil d'Hygiène Publique* has determined to establish "Houses of Refuge," into which, on the appearance of croup or any other contagious disease in one of their children, parents who are not in a position to protect their other children from contagion, may obtain admission for them.

—Dr. F. W. Campbell, in the *Canada Med. Record*, says that while none of the epileptic patients whom he had treated with nitro-glycerine have been entirely cured, all have been relieved, and the attacks became milder and fewer. The dose he usually employs is one drop of a one per cent. solution three times a day.

—According to the *Medical Times and Gazette*, of October 11, the *Lyon Médicale*, of October 5, states that a statistical enumeration shows that from the 17th of June to the 15th of September there have been about 5,000 deaths, distributed over 200 communes, which presupposes at least 10,000 or 12,000 cases of the disease.

—M. Gibier (*Progrès Médical*) inoculated rabic virus from bird to bird, and there the virus augmented in intensity with every inoculation. Instead of removing a disk with a trepan, as in dogs, and injecting through this opening the virus, he makes an opening with a gimlet. The inoculation into the anterior chamber of the eye produces rabies in 10 to 12 days.

—M. Eloy and M. Huchard ("Union Médicale") state that, in a series of thirty-six experiments upon animals, conducted by them, it was proved that the alkaloids of quebracho (especially the one known as aspidospermine) exercised a powerful antithermic action. They have also employed hypodermic injections of aspidospermine successfully in cases of typhoid fever, where quinine seemed to exercise no effect upon the temperature.

—It is stated that the two patients from whom Mr. Lawson Tait lately removed the uterine appendages at Bellevue Hospital have both recovered, making a happy issue out of the doubt that Mr. Tait felt as to the safety of doing the operation in a large general hospital and in the presence of a great number of spectators.

—Dr. W. J. Sinclair, in the first number of the new "Medical Chronicle," gives a general résumé of the German contributions on the subject of corrosive sublimate as a disinfectant in midwifery during the past year. The substance of his remarks is, briefly, as follows: Corrosive sublimate has largely replaced carbolic acid in several of the German lying-in hospitals, but there seems to be considerable diversity of opinion as to the value of the former substance and the dangers incurred by its free use. Stadfeldt, of Copenhagen, reports a death, with all the symptoms of mercurial poisoning, after a single intra-uterine injection of a solution of the sublimate, 1 to 1,500. Taenzler, of Breslau, states that he has used this solution freely in 624 cases, in four of which he observed symptoms of poisoning. He does not deny that there is danger in intra-uterine irrigation with corrosive sublimate, but suggests a means of avoiding it by firmly compressing the uterus after each injection, so that there shall be no fluid left in the cavity.

#### MARRIAGES.

DAVIS—JOHNSON.—October 9, 1884, in St. Mary's church, Classon ave., Brooklyn, N. Y., by Rev. D. V. M. Johnson, D. D., Irenæus P. Davis, M. D., of Milltown, N. J., and Miss Sarah A., daughter of the late R. A. S. Johnson, of New Brunswick, N. J. No cards.

GANDY—GRAHAM.—November 6, 1884, at the residence of the bride, No. 1418 Hanover street, Philadelphia, by Rev. W. D. Roberts, Charles M. Gandy, M. D., Surgeon in the U. S. army, and Miss Emma R. Graham.

LEET—FARNUM.—In West Unity, Vt., by Rev. C. H. Leet, of Gilmanton, Dr. James A. Leet, of Marlborough, and Jennie M. Farnum, of West Unity.

LIVEZEY—DEERING.—September 30, 1884, at the Cathedral parsonage, by Rev. Father Gallagher, Dr. J. D. Livezey and Miss Mary R. Deering, both of Philadelphia.

MACY—DEVÖE.—August 9, 1884, at the residence of the bride's parents, by Rev. John Chamberlain, Charles S. Macy, M. D., and Kate, daughter of Col. Thomas F. DeVoe.

PFEIFFER—FOLSOM.—In New York city, by Rev. Dr. S. H. Weston, of St. John's church, Dr. Oscar J. Pfeiffer, of Boston, and Annie Hale, only daughter of the late Samuel G. Folsom, of Portsmouth, N. H.

PHILLIPS—HOWELL.—October 30, 1884, at New York, in Grace Church Chantry, by Rev. Mr. Goodwin, John Leighton Phillips, Assistant Surgeon United States army, and Daisy Somerville, daughter of the late Thomas John Howell, of St. Louis.

SHULER—DAVIS.—January 31, 1884, in Raton, New Mexico, by Rev. J. McLaughy, J. J. Shuler, M. D., of Raton, and Mary K. Davis, of Memphis, Tenn.

#### DEATHS.

ARNOUX.—October 29, 1884, at Fort Lee, New Jersey, Edward F. Arnoux, M. D.

CLAYTON.—October 27, 1884, at Point Pleasant, N. J., Dr. William G. Clayton.

GARDETTE.—October 27, 1884, in Washington, D. C., Dr. Charles D. Gardette, only son of Dr. E. B. Gardette, of Philadelphia, aged 54 years.

HART.—October 30, 1884, in this city, Dr. Alexander C. Hart, aged 73 years.

MILLER.—November 1, 1884, at his late residence, 134 East 18th street, New York city, David B. Miller, M. D., son of Jane and the late John Miller, M. D.

METTLER.—November 1, Dr. D. B. Mettler, of New York city, aged 46.